DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Request for Applications (RFA) No. TI 03-009

Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment

Short Title: SBIRT

Part I- Programmatic Guidance

Receipt Date: July 2, 2003

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[Note to Applicants: To prepare a complete application, "Part II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements," must be used in conjunction with this document, "Part I - Programmatic Guidance."]

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration

Purpose of this Announcement

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2003 cooperative agreements to expand and enhance State substance abuse treatment service systems by:

- expanding the State's continuum of care to include screening, brief intervention, referral, and brief treatment (SBIRT) in general medical and other community settings (e.g., community health centers, school-base health clinics and student assistance programs, occupational health clinics, hospitals, emergency departments);
- supporting clinically appropriate treatment services for nondependent substance users (i.e., persons with a Substance Abuse Disorder diagnosis[1]) as well as for dependent substance users (i.e., persons with a Substance Dependence Disorder diagnosis);
- improving linkages among community agencies performing SBIRT and specialist substance abuse treatment agencies; and
- identifying systems and policy changes to increase access to treatment in generalist and specialist settings.

It is expected that approximately $22 million will be available for an estimated 7 State awards in FY 2003. The average annual award will range from $2,500,000 to $3,500,000 in total costs (direct and indirect). The State can choose to implement the project in as many sub-recipient communities[2] as the State wishes. For each sub-recipient community chosen, the State must demonstrate need and potential for systems change to rapidly initiate the SBIRT approach. Each sub-recipient community must receive sufficient funds to enable the State to document an impact using the SBIRT performance targets.

Cost sharing is not required in this program.

Applications with proposed budgets that exceed $3.5 million will be returned without review.

Awards may be requested for up to 5 years.

Annual continuation awards will depend on the availability of funds, progress achieved and compliance with the Government Performance and Results Act (GPRA) requirements. Financial incentives and reductions based on performance will be built into the program monitoring and continuation application process. States that can meet or exceed targets may be eligible to receive financial incentives to expand their effort to other communities. States that cannot meet their targets or demonstrate problems in implementation may receive no or reduced continuation funding.

[1] For purposes of this announcement, in accord with the National Drug Control Strategy's (NDCS) new approach to using diagnosis as the criterion for determining the size of the treatment gap, the need for treatment is discussed in terms of the categories used in the American Psychiatric Association **Diagnostic and Statistical Manual of Mental Disorders** (DSM-IV; 1994).

[2] For purposes of this announcement, a community may be a geopolitical unit (city, county), a health district or human services region, or a substate planning area as defined for purpose of allocating Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds.

Who Can Apply?

All States, Territories, and Federally recognized Indian tribes are eligible to apply but the applicant must be the immediate Office of the Governor of States (for Territories and Indian tribes, the Office of the Chief Executive Officer). The Governor must sign the application. **Applications not signed by the Governor are not eligible and will not be reviewed.** State-level agencies are not considered to be part of the immediate Office of the Governor and are not eligible to apply. This means, for example, that the State Substance Abuse Authority (SSA) or other State-level agencies within the Executive Branch cannot apply independently. SAMHSA has limited the eligibility to Governors of States because the immediate Office of the Governor has the greatest potential to provide the multi-agency leadership needed to develop the State's treatment service systems to increase the State's capacity to provide accessible, effective, screening, brief intervention, referral and brief treatment services to persons with Substance Use Disorders. States that have already begun to develop such integrated systems, stressing early intervention for persons at risk of dependence, are especially encouraged to apply.

The Governor will designate a lead official to be Program Director for the cooperative agreement. That individual may be, but is not required to be, part of the SSA. However, the services to be provided through this cooperative agreement program are to be integrated into the current system of care. Therefore, SAMHSA expects that the SSA will be involved in the project. All direct providers of treatment services involved in the proposed system of care must be in compliance with all local, city, county and State licensing and accreditation/certification requirements. Include appropriate Licensure/Accreditation/Certification documentation (or documentation supporting why the local/State government does not require Licensure/Accreditation/Certification) in **Appendix 1** of your application.

Any direct providers of services involved in the proposed continuum of care must also have been providing services for a minimum of two years prior to the date of this application. A list of the service providers and two-year experience documentation must also be provided in **Appendix 1** of your application. The list should provide a break out for each sub-recipient community.

Application Kit

SAMHSA application kits include the following:

1. PHS 5161-1 - *(revised July 2000)* **-** Includes the Face Page, Budget forms, Assurances, Certifications and Checklist.

2. PART I - of the Program Announcement (PA) or Request for Applications (RFA) includes instructions for the specific grant or cooperative agreement application. This document is Part I.

3. PART II - of the Program Announcement (PA) or Request for Applications (RFA)- provides general guidance and policies for SAMHSA grant applications. The policies in Part II that apply to this program are listed in this document under "Special Considerations and Requirements."

You must use all of the above documents of the kit in completing your application.

How to Get an Application Kit:

- Call: ***National Clearinghouse for Alcohol and Drug Information (NCADI) 1-800-729-6686***, or

- Download **Part I, Part II and the PHS 5161-1** of the application kit from the SAMHSA web site at www.samhsa.gov. Click on "Grant Opportunities" and then "Current Grant Funding Opportunities."

Where to Send the Application

Send the original and 2 copies of your cooperative agreement application to:

SAMHSA Programs
Mr. Ray Lucero
Review Branch/SAMHSA
Parklawn Building/Room 17-89
5600 Fishers lane
Rockville MD 20857

**Change the zip code to 20852 if you use express mail or courier service.

All applications MUST be sent via a recognized commercial or governmental carrier. Hand carried applications will not be accepted. Faxed or e-mailed applications will not be accepted. You will be notified by letter that your application has been received.

Be sure to type RFA No. TI 03-009, SBIRT in Item Number 10 on the face page of the application form.

Application Due Date

Your application must be received by July 2, 2003.

Applications received after this date must have a proof-of-mailing date from the carrier before June 25, 2003 **.**

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on program issues, contact:

Herman I. Diesenhaus, Ph.D.
SAMHSA/CSAT
5600 Fishers Lane/ Rockwall II, 7th floor
Rockville, MD 20857
(301) 443-6575
E-Mail: hdiesenh@samhsa.gov

Or

Jean Donaldson, M.A.
SAMHSA/CSAT
5600 Fishers Lane/ Rockwall II, 7th floor
Rockville, MD 20857
(301) 443-6259
E-Mail: jdonalds@samhsa.gov

For questions on grants management issues, contact:

Stephan Hudak
Division of Grants Management
SAMHSA/OPS
5600 Fishers Lane/ Rockwall II, 6th floor
Rockville, MD 20857
(301) 443-9666
E-Mail: shudak@samhsa.gov

Cooperative Agreements

Awards are being made as cooperative agreements because substantial Federal staff involvement is required in the funded project.

Grantees Must:

- Comply with the terms and conditions of the cooperative agreement award.
- Agree to provide SAMHSA with data required for the Government Performance and Results Act (GPRA).
- Collaborate with CSAT staff in project implementation and monitoring.
- Organize and conduct regular meetings of the project's Policy Steering Committee (PSC).
- Select 15 to 20 representatives from State and community resources to serve on the PSC.
- Implement and monitor activities of the cooperative agreement project, including accountability for sub-recipients' service delivery.
- Collect, evaluate, and report statewide treatment project and GPRA data.
- Respond to requests for program-related data.
- Document intended and actual systemic changes resulting from the project's activities.

SAMHSA Staff will:

- Collaborate in selection of PSC members, review and approve final membership.
- Work collaboratively with the Governor's office, project staff, and PSC members to finalize the plans for a comprehensive project management plan.
- Provide best practice program information, resource materials, and technical assistance, (e.g., examples of model programs, financing strategies and benefit designs, screening and assessment tools and protocols) to help grantees identify, select, and replicate science-based practices for implementing SBIRT.
- Provide guidance on how to assess resource allocation strategies in order to re-direct treatment resources toward an emphasis on nondependent users.
- Review and approve the comprehensive Project Implementation Plan to be submitted by the end of the third month for release of funds for Phase II and III implementation.
- Review and approve sub-recipient contracts and awards.
- Actively participate in PSC discussions.
- Work cooperatively with the Governor's office to make the transition from the cooperative agreement to State and local control and to sustain the system changes achieved by the project.

The Policy Steering Committee will:

- Provide strategic policy and operational advice on the SBIRT project to the Governor as well as advise on integrating SBIRT into the existing system of care and on policies, as appropriate.
- Consist of 15 to 20 members and a chair, to be appointed by the Governor.
- Represent the Office of the Governor and diverse stakeholders in the State, including, for example, representatives from:
    - Relevant State executive branch agencies (including the SSA), legislative committees, and judicial branch agencies
    - Community specialist treatment organizations
    - General and specialist healthcare organizations (e.g., Federally Qualified Community Health Centers, hospitals, family practice clinics, emergency departments, ob-gyn clinics)

- Occupational Health Clinics and Employee Assistance Programs or Human Resources Departments
- Student Health Centers and Student Assistance Programs
- Unions and Member Assistance Programs
- Professional and trade associations
- Recovery community organizations
- Community coalitions
- Training agencies and universities
- Employers and business coalitions
- Insurers and Managed Care Organizations

- Hold the initial meeting within 60 days of award and continue to meet once a month for the first year and quarterly in subsequent years.
- Coordinate with other State agencies, commissions, and offices (including the SSA) as appropriate.

Award Criteria

Decisions to fund a cooperative agreement are based on:

1. The strengths and weaknesses of the application as identified by the Peer Review Committee and approved by the Center for Substance Abuse Treatment National Advisory Council.

2. Availability of funds.

3. **Ability to move rapidly to award sub-recipient funds and to initiate SBIRT:** CSAT places considerable emphasis on rapid award of Federal funds by the State and implementation of individual projects by the sub-recipients. Preference will be given to States that demonstrate that they have the ability to move quickly (i.e., within 4 months) to allocate sub-recipient funds to initiate SBIRT and to States that have already established mechanisms for carrying out screening and brief interventions. Such screening and brief interventions may be offered either as treatment activities (e.g., pre-treatment, outreach or early intervention) or as indicated prevention efforts. Evidence that the State meets these criteria (e.g., copies of existing contracts, requests for proposals, memoranda of agreement) should be included in **Appendix 2** of the application.

4. Funding preference will also be given to states whose past performance demonstrates rapid award of CSAT grant funds. Documentation of past performance demonstrating rapid deployment of CSAT grant funds must be included in application **Appendix 2**.

5. **Need.** When determining the funding priority among those States with scored applications, additional consideration will be given to the size of the difference between need for treatment and capacity to provide treatment in the States and sub-recipient communities. The National Household Survey on Drug Abuse (NHSDA)[3] now is able to generate statewide estimates. (Epstein, 2002; OAS, 2002; Wright, 2002) Those estimates will be considered, along with other State determined indices of the size of the difference between treatment need/capacity Statewide and in local communities as provided in the narrative.

6. **Program Costs.** Per person costs per treatment admission will be taken into consideration. The following are acceptable ranges by treatment modality:

- Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services - $200 to $1,200

- Outpatient (Non-Methadone) - $1,000 to $5,000

[3] Renamed the National Survey on Drug Use and Health.

- Outpatient (Methadone) - $1,500 to $8,000

- Residential - $3,000 to $10,000

The grantee will be expected to compute per person costs for treatment provided under this initiative. Per person treatment costs for each modality should be computed by dividing the number of persons served in each modality by the amount of the project budget used to fund that program component after subtracting out the costs of required data collection and submission. The State will report these costs as well as provide a detailed explanation of how they were computed in their quarterly reports.

7. In its award decision-making process, SAMHSA will consider collaboration with applicants for the National Institutes of Health (NIH) program announcement, PA-02-168: Implementation Of Screening And Brief Interventions For Alcohol-Related Problems, jointly issued by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). The PA can be accessed at http://grants.nih.gov/grants/guide/pa-files/PA-02-168.html. Documentation of the proposed collaboration should be included in **Appendix 3** of the application.

Post Award Requirements

1. Grantees must submit quarterly and annual progress reports and applications for continued funding near the end of each year. Specific submission dates, instructions, and format will be provided by CSAT. These reports will be one part of the SBIRT-specific evaluation. Grantees will be held accountable for the information provided in the application as it relates to the number of persons to be served with the award funds. CSAT program officials will take into consideration a grantee's progress in meeting goals and objectives, and the grantee's failures and corresponding strategy for overcoming these problems when making an annual recommendation as to continuation of the cooperative agreement, and amount of any continuation award. A grantee's failure to meet its goals and objectives may result in reduction or loss of an award.

2. Grantees are required to attend and must budget for two technical assistance meetings in the first year and one in each of the remaining years. A minimum of four persons from each grantee is expected to attend the technical assistance meetings. Individuals who are required to attend technical assistance meetings are the project director, the individual responsible for overseeing clinical services in contracted providers participating in SBIRT, and the individual responsible for project GPRA reporting; the GPO will identify the fourth person once the award is finalized.

Additional meetings will be convened over the course of the project to bring together project leadership from each State (e.g., the Policy Steering Committee Chairs, Project Directors) to share experiences, discuss implementation, policy change, financing, and reporting issues and to compare models in order to bring this program to full scale nationally, both in other States and other communities within the participating States. The expenses for these meetings will be borne by SAMHSA/CSAT. Grantee meetings will normally be held in the Washington, DC, metropolitan area.

3. Grantees must develop a systematic approach to carrying out and paying for (1) screening for Substance Use Disorders (SUDs) and providing brief interventions (1 to 5 sessions), and brief treatment (up to 12 sessions) and appropriate follow up and monitoring for individuals who use drugs but are not yet dependent in healthcare and other appropriate community settings; and (2) referral, when indicated for those who are dependent or nondependent and nonresponsive

to an initial brief intervention, for assessment, treatment and rehabilitation, and appropriate follow up and monitoring in specialist substance abuse treatment settings.

4. Grantees must commit to and report performance against targets for (1) reducing drug use by patients receiving treatment through the SBIRT project; (2) increasing the number of persons with SUDs who receive treatment in each sub-recipient community; (3) increasing the number of community settings where SBIRT services are provided, and (4) providing treatment services within approved cost parameters for a given treatment modality.

5. Community service sites doing SBIRT may not use cooperative agreement funds to provide other health or social services.

6. Funds may not be used to provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities or in custody where they are not free to move about in the community).

7. During the course of the project, grantees are responsible for ensuring that all direct service providers participating in the project continue to meet all local, city, county, and State licensing, certification or accreditation requirements as well as project reporting requirements (i.e., GPRA client monitoring).

8. Grantees must inform the SAMHSA/CSAT Project Officer of any publications based on the project.

9. Grantees must provide information needed by SAMHSA to comply with the Government Performance and Results Act (GPRA) reporting requirements. GPRA mandates accountability and performance-based management by Federal agencies, focusing on results or outcomes in evaluating the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives. In using up to 10% of their awards for the collection and reporting of GPRA data, the grantee must ensure that all sub-recipients meet the GPRA requirements. GPRA measures required, in addition to the targets specified in Number 4 above, are included in Appendix C of this document.

10. Grantees must submit a final report. Specific submission dates, instructions, and format will be provided by CSAT. The final report must summarize information from the quarterly reports and describe the accomplishments of the project and planned next steps for sustaining the systems and service changes developed during the cooperative agreement period.

Program Overview

Background

For demand reduction, the 2002 National Drug Control Strategy (NDCS) emphasizes (1) preventing initiation of drug use for those who have not initiated illegal drug use, (2) intervening early with those who have initiated illegal drug use but are not yet dependent, and (3) improving treatment for those who are dependent on drugs. (ONDCP, 2003)

Federal programs, including those operated by SAMHSA/CSAT, have tended to emphasize either universal prevention strategies aimed at those who have never initiated use (Haggerty and Mrazek, 1993) or specialist treatment for those who are dependent (Gerstein and Harwood, 1990). Little attention has been paid to the large group of individuals who use drugs but are not, or not yet, dependent and who could successfully reduce drug use through "early intervention." (Klitzner et al., 1992; Fleming, 2002). There is an emerging body of research and clinical experience that supports use of the SBIRT approach as providing effective early intervention for those persons who are nondependent users of illicit drugs (e.g., Barry

1999; Bernstein et. al, 1997; Zweben and Fleming, 1999; Roffman, 1999; Broskowski and Smith, 2001; Heather, 2001; Dennis, et al., 2002; Babor, et al., 2002; Blow, 1998; Fleming 2002).

Because the specialist treatment system alone cannot address the needs of all those persons diagnosed with either a Substance Abuse or Dependence Disorder, new program efforts are needed to provide funding to introduce or expand screening and brief intervention and brief treatment for nondependent users (i.e., those persons diagnosed with a Substance Abuse Disorder). These new program efforts should be initiated in primary health care centers and other generalist community settings (e.g., trauma centers/emergency rooms, ob-gyn clinics, occupational medicine programs, schools with student assistance programs and student health services, welfare offices, and worksites with occupational health clinics and employee assistance programs).[4]

The SBIRT initiative is intended to assist States in redesigning their current continuum of care to implement a comprehensive system that effectively identifies, treats, and provides continued management support for persons with substance use problems in both community and specialist settings as required by their clinical status.

[4] There are two usages for the term community-based substance abuse treatment: (1) specialist treatment services that are not hospital based; and (2) community institutions whose primary function does not involve identification and treatment of substance use problems but serves another human service function: general health care, education, social service, employment and vocational training, and criminal justice. (IOM, 1990; Rivto and Shore, 1999; Horgan et al., 2001) Persons with substance use problems can be identified in a wide variety of health care, social services, educational, corrections, and specialty mental health organizations; it is in this second sense that the term "community settings" is used here.

For purposes of this announcement, CSAT will not require a specific protocol for carrying out screening, assessment, brief intervention, brief treatment, and referral or require a specific number of sessions for either brief treatment or brief intervention. For this cooperative agreement program, the applicant will be required to describe their current protocol, identify which methods of screening, placement, brief intervention, referral, assessment, and brief treatment they will be using, and provide a justification for their procedures (including a discussion of the evidence for effectiveness). To enable cost determinations under this RFA, brief interventions are considered to be 1 to 5 sessions in length and brief treatment to be 6 to 12 sessions.

Building on prior research done under the auspices of the National Institute on Drug Abuse (Roffman et al., 1988; Stephens et al., 1994; Karroll, 1998; NIDA, 1999; Stephens et al., 2000), CSAT has recently supported development and evaluation of manualized brief intervention and brief treatment strategies for adolescents and adults with marijuana use disorders that can be utilized. (Godley et al, 2001; Copeland et al., 2001; Sample and Kadden, 2001; Clark et al., 2002; White and Dennis, 2002; Diamond et. al., 2002; Stephens et al., 2002)

Additional background and references for protocols and methods for carrying out activities required to implement the SBIRT program can be found in Appendices A and D.

Program Requirements

States must utilize at least ninety percent (90%) of their proposed budget for the sub-recipient communities to provide services and report performance. Up to ten percent (10%) of the award will be available to the State for activities

needed to carry out (1) project administration, (2) policy and systems change, (3) training and technical assistance, (4) monitoring sub-recipients' service delivery and reporting, and (5) reporting.

States will be required to devote the majority (75%) of their cooperative agreement services funds to expand and enhance their systems to carry out screening and brief intervention for drug use disorders in community agencies and the referral linkages to specialist treatment agencies.

While the focus of this initiative is on screening and brief intervention for nondependent users in community settings, it is critical to ensure that appropriate services are available to treat persons who are screened and for whom brief interventions in community settings are not appropriate. Accordingly, States may use a portion (up to 15%) of the cooperative agreement services funds to expand services in the other specialty modalities (brief treatment, outreach/ pretreatment services, outpatient (non-methadone), outpatient (methadone), and residential) for dependent persons who require more intensive and prolonged traditional treatments for a Substance Use Disorder.

States that do not seek to utilize part of this funding to close existing gaps in their treatment continuum will need to provide evidence to SAMHSA/CSAT that the State's system of treatment in each sub-recipient community already provides sufficient capacity and services (modalities) for all nondependent and dependent persons who will be identified through the new SBIRT programs initiated under this award.

The State may choose to hold back 10% of the funds devoted to service provision for reporting or require the sub-recipients to use 10% of their allocations for reporting.

Systems Change Considerations. To implement policies that will successfully attract and effectively treat individuals with Substance Use Disorders, the State will need to demonstrate that its systems change plan reflects an understanding of the general reasons that people do not seek services, as well as recognize how these general barriers that prevent individuals from successfully accessing the clinically appropriate level of care may apply to their State's system of care.

A substantial body of research is related to barriers to access to health care in general, and treatment for Substance Use Disorders, and there are various approaches to identifying and classifying barriers (IOM, 1990; Fiorentine, 1993; Schmidt and Weisner, 1999; PLNP, 2000). Less is known about those enabling factors that increase help-seeking and access (Grant, 1997; Weisner and Schmidt, 2001; Fortney and Booth, 2001).

Of major concern is the numerous studies documenting the failure of primary care physicians to identify persons at risk of or already experiencing a Substance Use Disorder and initiating the appropriate referral for evaluation and treatment. (Saitz et al., 1997; Hack and Adger, 2002; CASA, 2002) Such identification in mainstream medical care settings is necessary because perceived illness severity and stigma also may act as a barrier to treatment.

Addiction policy and service provision in States occur within the context of both general health systems and financing arrangements and carved out specialty prevention and treatment systems and financing arrangements. (Denmeade and Rouse, 1991) The implications of these arrangements in your State for the diffusion of SBIRT necessitate consideration in project formulation and implementation. Financial accessibility implies that the cost of the service is reasonable and there is no disincentive to use

needed services because of their costs or the method of reimbursement. However, many studies identify barriers due to the manner in which substance abuse treatment is financed, such as a lack of parity with physical illness in commercial and public insurance leading to high co-pays and restrictions of payment for diagnostic assessments; lack of coverage for nontraditional specialist treatment modalities (e.g., residential therapeutic communities) or payment for screening services in emergency departments and primary care settings (Reader and Sullivan, 1992; Buck and Umland, 1997; Sing et al., 1998; Rivara et al., 2001).

Another often cited barrier is the multiple, separate, fragmenting Federal, State, local, and private funding streams operated by frequently uncoordinated agencies[5] that have different coverage policies, codes, and procedures for treatment modalities and ancillary services, different eligibility criteria for providers and patients, different reporting requirements, different placement criteria, and inconsistent benefit designs (Gerstein and Harwood, 1990; Schlessinger et al., 1991; Horgan and Larson. 1998; Moss, 1998; Johnson, 1999).

Eliminating these barriers through systems and policy change is a major emphasis of this program (e.g., Pauly, 1991; Libertoff, 1999; Zarkin et al., 1995). Integrating SBIRT in community settings will require the State to conduct an analysis of the inhibiting and facilitating policies and practices in order to remove the institutionalized barriers and describe how the State will facilitate access to clinically appropriate treatment in the expanded continuum of care, starting with screening for Substance Use Disorders in community settings.

[5] The complexity of these multiple treatment subsystems at the State level has recently been described in a report submitted to SAMHSA/CSAT by the National Association of State and Drug Abuse Directors (NASADAD, 2002)

Program Design Considerations. Participating States will be expected to adopt and implement a treatment system that includes all of the following components:

- Screening, Identification, Brief Intervention, Referral, and Brief Treatment. This involves implementation of a system within community and specialist settings that screens for and identifies individuals with substance use-related problems. Depending on the level of problems identified, the system either provides for a brief intervention within the generalist setting, when appropriate, or motivates and refers the individual with a high level of problems and probable diagnosis of Substance Dependence Disorder to the specialist setting for assessment and diagnosis and either brief or long-term treatment. This includes training in self-management and involvement in mutual help groups, as appropriate. (Workgroup on Substance Abuse Self-Help Organizations, 2003)

- Sequential Assessment and Diagnosis. This involves having a system in place that assures that individuals who screen positive for substance use-related problems are appropriately assessed for the presence of Substance Use Disorders and co-morbid physical and mental disorders so that a diagnosis is made, an initial treatment plan developed, and a referral is made to the clinically appropriate community or specialist treatment setting for implementation and revision as dictated by the person's clinical status.

- Treatment. This involves having a system in place that assures that individuals who are diagnosed with a Substance Use Disorder are provided an opportunity to undergo an integrated pharmacological and psychosocial treatment regimen in order to reduce or eliminate their harmful consumption and its

adverse effects in the clinically appropriate community or specialist treatment setting. (NIDA, 2000) This includes training in self-management and involvement in mutual help groups, as appropriate.

- Continued Management Support. This involves having a system in place that assures that individuals who complete their formal treatment episode will receive long-term management support (care management) as appropriate for their level of disability and relapse potential in the clinically appropriate community or specialist treatment setting. This includes training in self-management and involvement in mutual help groups, as appropriate.[6]

The focus of the SBIRT program is on that part of the continuum of care that addresses treatment of Substance Use Disorders and not the treatment of Substance Induced Disorders, namely Substance Intoxication and Substance Withdrawal. The focus is on identifying the level of substance use problems for stabilized individuals presenting in community settings.

Patients manifesting signs of intoxication, withdrawal symptoms, and other physical problems that require emergency care or urgent action would be managed in other components of the generalist or specialist treatment systems. While stabilization and detoxification may be required for some persons presenting to community agencies, the availability of treatment resources, financing mechanisms, and other access barriers vary from those encountered in treating individuals who do not require withdrawal and stabilization.

This variation is recognized in the differentiation of the levels and settings of services for detoxification and rehabilitation in the latest version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM PPC-2R, 2000; Gastfriend et al., 2000) and the guidelines developed by the Evidence-Based Clinical Practice Guideline Working Group for the Veterans Health Administration, and the Department of Defense (2001).

Project Phases and Operations. There will be three phases to the project: project planning and start-up; operations; and phase-out.

Phase I: Project Planning and Start-up. This phase is expected to last approximately six months, during which CSAT will work collaboratively with the Governor's office, project staff, and Policy Steering Committee members to finalize the plans for a comprehensive project implementation and management plan spanning the full project period (up to 5 years, as determined by progress made and funding availability) and to initiate the activities. The start-up tasks to be completed in this phase are, at a minimum:

- selecting the members of the Policy Steering Committee (and subcommittees, if appropriate);
- developing a solid organizational structure that involves or enlists the participation of an appropriate array of service providers and funders required to serve the needs of alcohol and drug-involved individuals in the sub-recipient communities, representing the full spectrum of community and specialist services;
- refining the project management, reporting, quality improvement, and cost control mechanisms;

[6] References and resources that support this model, including CSAT Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs) are included in Appendices A and D.

- refining the needs assessment and survey of existing system gaps and precisely identifying the target populations and communities to be served;

- refining the plan to provide training and technical assistance, including information about SBIRT methods, training for staff in the community and specialist settings in carrying out SBIRT, and technical assistance to the overall project and its sub-recipients;

- finalizing all necessary inter-agency agreements, contracts, sub-contracts, billing procedures and fiscal controls, reporting and monitoring procedures with the agency or agencies in the selected communities that will deliver services;

- introducing reporting instruments and obtaining baseline data covering existing levels of service, patient/client needs and program performance characteristics as well as training and technical assistance provided and received;

- developing a plan for garnering and sustaining necessary policy changes and resources required to continue the project following the period of Federal support;

- demonstrating that required resources not included in the Federal budget request are adequate and readily accessible;

- initiating service delivery in the expanded continuum of care in each sub-recipient target community, if required;

- establishing the mechanism for monitoring performance against targets for (1) reducing drug use by patients receiving treatment through the SBIRT project; (2) increasing the number of persons with SUDs who receive treatment in each sub-recipient community; (3) increasing the number of community settings where SBIRT services are provided; and (4) providing treatment services within approved cost parameters for each treatment modality; and

- submitting an acceptable final Project Implementation Plan that includes specific objectives and milestones, implementation time frames and designation of staff responsible for accomplishing individual program objectives.

Release of funds for project implementation will be contingent on CSAT approval of the Project Implementation Plan finalized during the initial phase and submitted for approval by the end of the third month following award. At the conclusion of Phase I, every component of the project should be fully operational.

Phase II: Operations. This phase is expected to last approximately four years and three months, during which period CSAT will work collaboratively with the Governor's office, project staff, SSA, and other relevant agencies, Policy Steering Committee members, and sub-recipients to implement the project management, monitoring and reporting, training, technical assistance to sub-recipients, and service delivery activities. In Phase II, grantee will be responsible for these activities:

- Policy Steering Committee (and its subcommittees, if appropriate) operations, including regular meetings, monitoring project activities and achievements (viz., the specific objectives and milestones, implementation time frames and designation of staff in the Project Implementation Plan), and communications with the Governor;

- determining the need for and providing the requisite training and technical assistance needed to achieve project goals;

- project management, reporting, quality improvement, and cost control;

- managing the continuation award process to the sub-recipients;

- accomplishing and tracking systems change (i.e., overcoming funding and other resource barriers, policy changes, improving linkages among specialist and community agencies, providing training and technical assistance, carrying service delivery in the expanded continuum of care in each sub-recipient target community; and achieving the targets for (1) reducing drug use by patients receiving treatment through the SBIRT project; (2) increasing the number of persons with SUDs who receive treatment in each sub-recipient community; (3) increasing the number of community settings where SBIRT services are provided; and (4) providing treatment services within approved cost parameters for a given treatment modality; and

- refining operations as barriers are encountered and lessons learned through feedback from the monitoring and reporting systems.

Phase III: Phase-Out. During the final three months of the cooperative agreement award, CSAT will work cooperatively with the Governor's office, project staff, and Policy Steering Committee members, and sub-recipients to make the transition from the cooperative agreement to State and local control and to sustain the system changes achieved by the project.

Data Collection, Monitoring, and Reporting.

Grantees must provide information needed by SAMHSA to comply with the Government Performance and Results Act (GPRA) reporting requirements. GPRA mandates accountability and performance-based management by Federal agencies, focusing on results or outcomes in assessing the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives. In allowing grantees to utilize a portion of their awards for the collection and reporting of GPRA data, the grantee must ensure that all sub-recipients meet the GPRA requirements.

Grantees must submit quarterly and annual progress reports and applications for continued funding near the end of each year. Grantees also must enter client level data as specified below on a continuous basis[7] throughout the life of the grant. Specific submission dates, instructions, and format will be provided by CSAT. Grantees will be held accountable for the target number to be served proposed in their grant application and the number reported as having been served will be compared to the target proposed in the application. When making an annual recommendation as to continuation of the cooperative agreement, and amount of any continuation award, CSAT program officials will take into consideration a grantee's progress in meeting goals and objectives, and the grantee's failures and corresponding strategy for overcoming these problems. A grantee's failure to meet its goals and objectives may result in reduction or loss of an award.

Applicants should carefully note that there are 4 categories of services or combinations of services to be supported by these cooperative agreement funds and each category has specific reporting requirements with regards to GPRA. The following GPRA data collection methodology is congruent with the existing outreach methodologies and other GPRA data collection activities currently being employed by CSAT.

[7] Continuous reporting is defined as entering client level data into the GPRA web based data system within 7 business days of collection.

The four categories of services or combinations of services to be provided to individuals include:

- Screening Only
- Screening and Brief Intervention
- Screening and Brief Treatment
- Screening and Other Treatment for Substance Use Disorders.

The following are the reporting requirement for each category:

Screenings Only

Aggregated Data:
For clients who are screened and do not require any level of substance abuse treatment services, the following will be required for each State and/or each community, if applicable:

- Aggregated counts (unduplicated) and demographic characteristics of persons screened for each quarter and to date;

- Aggregated counts of the number and types of settings where SBIRT services are provided for each quarter and to date;

- Aggregated counts (unduplicated) of the number of people with substance use disorders who receive treatment services for those disorders and the percentage of those in need of such treatment services for each quarter and to date;

This mandatory information is reported to CSAT via the grantees quarterly report[8].

Screening and Brief Intervention:

For all clients that are screened and require brief intervention the following must be collected and reported:

Baseline Client Level Data: Baseline (at screening) CSAT GPRA data elements limited to the demographic, and substance use domains must be collected on all clients in this category of service (see Appendix C, items A1, B1, B2 and H)[9]. This individual client level data will be used to count unduplicated clients served. It is important that all clients complete a tracking information sheet in the event they are selected for follow-up.

This information must be reported via client level data entry on the CSAT GPRA web-site at www.csat-gpra.org, as soon as OMB approves the data collection package. States will be able to download data from this existing site for its own use.

Follow-up Client Level Data: For a **representative sample** of clients in this category, who were screened and required brief intervention, follow-up GPRA data limited to the substance use domain (See Appendix C, items A1, B1, B2, H, I, and J) must be collected at 6 months after baseline and entered into the CSAT web based GPRA data entry and reporting system. The sampling strategy will be designed by a CSAT contractor with State and CSAT collaboration and the sample size will be as small as possible, but sufficient so that the results can be generalized to all of those who received brief intervention supported by the cooperative agreement within the State. Grantees will be notified which clients have been selected as part of the representative sample and need to be located for follow-up via a web based notification report. Grantees are expected to achieve a follow-up rate of at least 80% of those selected.

Aggregated Data: In the quarterly report, the State must also provide data about the costs for the delivery of screening and brief intervention, including the mean, median, and range of costs

[8] OMB approval for these aggregated measures will be sought.

[9] OMB approval for using this more limited data set will be sought.

overall, by facility type, and region and sub-recipient, if applicable. The State must also discuss how such costs compare to the CSAT approved cost parameters for screening and brief intervention and what efforts they are undertaking to bring costs into line with those expected.

Screening and Brief Treatment or Screening and Other types of Treatment for Substance Use Disorders:

For all clients that are screened and require either brief treatment or other treatment, the following must be collected and reported:

Baseline Client Level Data: Baseline (at screening) using all of the CSAT GPRA data elements must be collected on all clients in this category of service (see Appendix C, items A through J). This information is reported into the CSAT GPRA web-site at www.csat-gpra.org. It is important that all clients complete a tracking information sheet in the event they are selected for follow-up.

Follow-up Client Level Data: For a **representative** sample of clients in this category that were screened and required substance abuse services beyond brief intervention, follow up data (all domains, see Appendix C, Items A through J) will be to be collected at 6 months after the initiation of substance abuse treatment services on a representative sample. The sampling strategy will be designed by a CSAT contractor with State and CSAT collaboration, and will be as small as possible, so that the results can be generalized to all of those who received brief intervention supported by the cooperative agreement within the State. The system will determine which clients need to be follow-up via a web notification report. These client level data are to be entered into the CSAT GPRA data entry and reporting system.

Aggregated Data: In the quarterly report, the State must also provide data about the costs for the delivery of screening and brief treatment as well as all other treatment modalities supported by this cooperative agreement including the mean, median, and range of costs overall, by modality, facility type and region, and sub-recipient, if applicable. The State must also discuss how such costs compare to the CSAT approved cost parameters for screening and brief intervention and what efforts they are undertaking to bring costs into line with those expected.

Grantees must comply with GPRA data collection and reporting requirements, including continuous reporting[10] of progress in meeting the targets proposed (in the application) for the number of persons to be served and the collection of the specified CSAT GPRA Core Client Outcomes at specified time points. Grantees are required to collect and report client level data for the overall project and each sub-recipient using the CSAT GPRA web based data reporting system. Appendix B contains a detailed description of CSAT's GPRA strategy. Full baseline GPRA and follow-up data are to be entered on line at www.csat-gpra.org. (CSAT will provide Grantees with user names and passwords as well as data entry training).

CSAT GPRA requirements for this specific RFA include data collection and real time reporting about cooperative agreement-supported service recipients at baseline/intake, and 6 months after intake, as noted above. Grantees are expected to collect individual level baseline GPRA data on all persons served, (those who receive at least screening and brief intervention), through the cooperative agreement on a minimum of eighty percent (80%) of all clients in the representative sample. Grantees also are required to submit specified aggregate data in quarterly reports.

[10] Continuous reporting is defined as entering client level data into the GPRA web based data system within 7 business days of collection.

Grantees should consider these requirements when preparing the data collection, monitoring, and reporting budget section of the application.

Funds may not be used to pay for incentives to induce clients to enter treatment. However, a grantee or treatment provider may provide up to $20 or the equivalent (coupons, bus tokens, and vouchers) to clients as an incentive to participate in the required GPRA data collection Follow-up. This amount may be paid for participation in each required interview.

CSAT's GPRA Core Client Outcome domains are:

Number of individuals served;

Ages 18 and above: Percent of service recipients who: have no past month substance abuse; have no or reduced alcohol or illegal drug consequences; are permanently housed in the community; are employed; have no or reduced involvement with the criminal justice system; and, have good or improved health and mental health status.

Ages 17 and under: Percent of service recipients who: have no past month use of alcohol or illegal drugs; have no or reduced alcohol or illegal drug consequences; are in stable living environments; are attending school; have no or reduced involvement in the juvenile justice system; and, have good or improved health and mental health status.

Applicants must clearly state which GPRA service population(s) they propose to address as target populations. For more information, as well as the electronic versions of the CSAT GPRA materials, go to: www.csat-gpra.org.

Other Reporting Requirements

While a formal local evaluation is not required, the grantee will be expected to monitor implementation of the project and its fidelity to their plan, and to document the State-level and the sub-recipient community level and provider agency level activities, accomplishments, and outcomes. The grantee will also be expected to provide regular feedback to the project managers, staff, and Policy Steering Committee to ensure fidelity and improve operations and services. This feedback should include both process and outcome measures. Process components must, at a minimum, address:

Baseline (at the initiation of SBIRT) aggregate (unduplicated) counts of the number of individuals screened for substance use disorders in the State and each community, if applicable;

Aggregated baseline (at the initiation of SBIRT) counts of settings where SBIRT services are provided in the State and aggregated characteristics of such settings;

Average and median per person cost of screenings, and if applicable, average costs per community where SBIRT has been introduced into multiple communities;

Aggregated baseline of the number of people (unduplicated count) within the State with SUD's who receive treatment services for these disorders; and the percentage of those in need of such treatment services that the baseline represents; similar information for communities if SBIRT was introduced into multiple communities.

Data collection for these data elements (and related information) outlined above and reported in quarterly reports, will be discussed and verified during an annual interview with a CSAT contractor, either conducted in-person or by telephone, with appropriate, knowledgeable project staff. This interview will require OMB approval[11].

[11] OMB approval for this interview protocol will be sought by CSAT.

Target Populations and Sub-recipient Communities

Because of legal, funding, and programmatic issues, most States have developed different continuums of care for treatment of pre-adolescent children, youth (ages 12-17 years), adults, and elderly persons. States can apply for SBIRT cooperative agreements for one, a combination, or all of these target populations.

The State can choose to implement the project in as many sub-recipient communities as the State wishes. For each community selected, the application will need to identify the lead agency selected (if any) and all potential sub-recipient(s) who will be providing services or training and technical assistance. For each community selected, the application will need to document the community's need and potential for systems change to rapidly initiate SBIRT.

While SBIRT can be carried out in all community generalist settings (e.g., healthcare, welfare, worksite, criminal justice), the State may choose to implement the project in one generalist system. If so, starting with the general medical system is recommended.

The State may contract with a lead agency that routinely serves as the local administrator of funds for identifying and treating persons with Substance Use Disorders (such as a local health department or a county substance abuse authority) or with multiple generalist and specialist agencies that contractually agree to work together to provide a continuum of care including SBIRT for any or all defined community service areas. Sub-recipient agencies may be public and domestic private non-profit entities, including faith-based organizations.

What to Include in Your Application

In order for your application to be complete, it must include the following in the order listed. Check off areas as you complete them for your application.

❑ **1. FACE PAGE**

Use Standard Form 424, which is part of the PHS 5161-1. See Appendix A in Part II of the RFA for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

❑ **2. ABSTRACT**

Your total abstract should not be longer than 35 lines. In the first 5 lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

❑ **3. TABLE OF CONTENTS**

Include page numbers for each of the major sections of your application and for each appendix.

❑ **4. BUDGET FORM**

Standard Form (SF) 424A, which is part of the PHS 5161-1 is to be used for the budget. Fill out sections B, C, and E of the SF 424A. Follow instructions in Appendix B of Part II of the RFA.

❑ **5. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION**

The Project Narrative describes your project. It consists of Sections A through D. These sections may not be longer than 35 pages. More detailed information about Sections A through D follows #10 of this checklist.

❑ **Section A –** Establishing Need

❑ **Section B** – SBIRT Implementation and Systems Change

❑ **Section C** - Project Organization, Management, and Staffing

❑ **Section D -** Data Collection, Monitoring, and Reporting

The Supporting Documentation section of your application provides additional information necessary for the review of your application. This Supporting Documentation should be provided immediately following your Project Narrative in Sections E through H. There are no page limits for these sections, except for Section G, the Biographical Sketches/Job Descriptions.

☐ **Section E -** Literature Citations. This section must contain complete citations, including titles, dates, and all authors, for any literature you cite in your application.

☐ **Section F -** Budget Justification, Existing Resources, Other Support. You must provide a narrative justification of the items included in your proposed budget as well as a description of existing resources and other support you expect to receive for the proposed project. **(See Part II of the RFA, Example A, Justification).**

☐ **Section G** - Biographical Sketches and Job Descriptions

- Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. If the person has not been hired, include a letter of commitment from the individual with a current biographical sketch.

- Include job descriptions for key personnel. They should not be longer than **1 page**.

- **Sample sketches and job descriptions are listed <u>on page 22</u>, Item 6 in the Program Narrative section of the PHS 5161-1.**

☐ **Section H - SAMHSA's Participant Protection.** The elements you need to address in this section are outlined after the Project Narrative description in this document.

<u>6. APPENDICES 1 THROUGH 5</u>

- Use only the appendices listed below.
- **Do not** use appendices to extend or replace any of the sections of the Project Narrative unless specifically required in this RFA. Reviewers will not consider them if you do.
- **Do not** use more than **30 pages** (plus all instruments) for the appendices.

Appendix 1: Provide a listing of all community and specialist service providers, including:

- documentation of Licensure/ Accreditation/Certification or a letter from the licensure/accreditation/ certification authority stating that it is not required;

- documentation of at least two years of experience in delivering substance abuse treatment for specialist providers;

- identification of the sub-recipient community within the State where the provider will deliver services;

- a listing of modalities and services provided in the project; and

- if the modalities that the State funds within its continuum of care do not match those for which CSAT tracks for GPRA and calculates program costs, provide a cross-walk that aligns your modalities and costs with those that CSAT tracks.

Appendix 2: Letters of Commitment, Contracts, Agreements, Table of Organization, Performance Schedule, Task-Sequencing Chart, Documentation from the Governor certifying rapid obligation of funds, and Documentation of past performance demonstrating rapid deployment of CSAT grant funds.

Appendix 3: Documentation of any proposed collaboration with applicants to the NIH PA-02-168 announcement.

A plan, budget, budget justification and signed agreement for training and technical assistance.

Appendix 4: Data Collection Instruments/ Interview Protocols

Appendix 5: Sample Consent Forms

❑ **7. ASSURANCES**

Non-Construction Programs. Use Standard form 424B found in PHS 5161-1.

❑ **8. CERTIFICATIONS**

Use the "Certifications" forms, which can be found in PHS 5161-1. See Part II of the RFA for instructions.

❑ **9. DISCLOSURE OF LOBBYING ACTIVITIES (See form in PHS 5161-1)**

Appropriated funds, other than for normal and recognized executive-legislative relationships, may not be used for lobbying the Congress or State legislatures. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. (Please read **Part II** of the RFA**,** General Policies and Procedures for all SAMHSA Applications for additional details.)

❑ **10. CHECKLIST** (Found in the PHS 5161)

You must complete the Checklist. See Part II Appendix C of the RFA for detailed instructions.

Project Narrative

Sections A through D

In developing your application, use the instructions below that have been tailored to this program. These are to be used in lieu of the "Program Narrative" instructions found in the PHS 5161 on page 21.

Sections A through D are the Project Narrative of your application. These sections describe what you intend to do with your project**.** Below you will find detailed information on how to respond to Sections A through D**.** Sections A through D may not be longer than 35 pages.

- **Your application will be reviewed and scored against the requirements described below for sections A through D. These sections also function as review criteria.**
- A peer review committee will assign a point value to your application based on how well you address **each** of these sections.
- The number of points after each main heading shows the maximum number of points a review committee may assign to that category.
- Bullet statements do not have points assigned to them; they are provided to invite attention to important areas within the criterion.

- Reviewers will also be looking for evidence of cultural competence **in each section** of the Project Narrative. Points will be assigned based on how well you address cultural competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in Part II of the RFA, Appendix D.

Section A: <u>Establishing Need</u> 20 points

- Describe the need for treatment Statewide and for each community in which SBIRT will be implemented. Include as much documentation as possible, with the focus on differentiating clinically appropriate treatment for persons diagnosed with a Substance Abuse Disorder versus a Substance Dependence Disorder.

Note: Documentation of treatment need, demand, barriers to access, and resource availability may come from a variety of qualitative and quantitative sources. (Dewit and Rush, 1996; NIDA, 1998; Weisner, 2001; McAuliffe, 2002) The quantitative data could come from locally generated data or trend analyses, from State data such as that available through State Treatment or Prevention Needs Assessments, social indicator analyses, waiting list analyses, and/or through national data sets, such as that available from SAMHSA's National Household Survey on Drug Abuse (NHSDA), Drug Abuse Warning Network (DAWN), and Drug and Alcohol Services Information System (DASIS), which includes the National Survey of Substance Abuse Treatment Services (N-SSATS) and the Treatment Episode Data Set (TEDS), and DOJ's Arrestee Drug Abuse Monitoring (ADAM) program. The description and data will provide the baseline for monitoring performance against the SBIRT targets.

- Describe the State's current resources and continuum of care for persons with Substance Use Disorders including—the provider and practitioner resources and the funding streams available for intervention and treatment services in the generalist and specialist systems.

- Describe how the State currently plans for, funds, and provides intervention and treatment services within its continuum of care (including SBIRT if it is part of the current continuum of care) and how SBIRT (or SBIRT expansion) can be integrated into the financing and provider systems. Include a discussion of the use of patient placement criteria and standardized screening and sequential assessment protocols, if these are used, and the modalities in which persons are placed. If the modalities that the State funds do not match those for which CSAT calculates program costs, provide a crosswalk that aligns your modalities and costs for each with those that CSAT tracks for GPRA (screening, brief intervention, brief treatment, outreach/pretreatment services, outpatient (non-methadone), outpatient (methadone), and residential). Where necessary, include the crosswalk between CSAT program cost modalities and the State's continuum of care in **Appendix 1**.

- Explain why the existing services are insufficient or inappropriate to respond to the demand for services and the treatment needs of the target population chosen for this application.

- Provide a description and analysis of the three most important barriers existing that prevent persons who need and seek treatment from accessing the clinically appropriate type and level of treatment. Barriers to be addressed might include laws, regulations, eligibility requirements for service receipt, facility and provider eligibility requirements, varied funding streams, coverage limitations, lack of patient placement criteria or

standardized screening and sequential assessment protocols, etc.

- Target Communities. Describe your method for selecting the communities for which funding is to be directed to increase services. Document for each how the need for treatment significantly exceeds the capacity to provide services, the potential for systems change, and that strategies exist to rapidly initiate SBIRT. Provide the same information about need, resources, and barriers for each community in which the project will be implemented that has been provided for the State. Where policies are the same Statewide so indicate, and describe only local variations (e.g., a local tax used to fund prevention or treatment).

Section B: SBIRT Implementation and Systems Change 40 points

- **Systems Change:** Provide a detailed Project Implementation Plan that explains how the Governor proposes to use project funds in conjunction with other available funding sources to provide SBIRT services. All funding sources that are or could be used to pay for screening and treatment of Substance Use Disorders (e.g., State General Fund, Medicaid, Preventive Health and Health Services Block Grant, Community Health Center grants, commercial insurance, Substance and Abuse Prevention and Treatment Block Grant, Temporary Assistance for Needy Families (TANF) Block Grant, Child Care and Development (CCDF) Block Grant, Maternal and Child Health Block Grant) should be addressed, but the focus should be on the three **major** funding streams that you will use to increase support and decrease barriers.

- Describe how the State will increase the number of generalist settings that provide SBIRT in each sub-recipient community as a result of the award and redirection of other funding sources.

- **Service Delivery:** Describe how the State will provide SBIRT within its continuum of care, within the geographic areas proposed, including a description of the modalities and services to be provided, the protocols that will be used for standardizing screening, assessment, determining the level of service required, referral, brief intervention, brief treatment, and follow up. Provide a justification for the procedures to be used, including a discussion of the evidence for effectiveness. The modalities and services described should match those listed in **Appendix 1**.

- If the State chooses to expend funds for other treatment modalities within the continuum of care, describe how these services will be implemented. States that do seek to fund specific components of their continuum of care through the SBIRT cooperative agreement must provide evidence that there is a sufficient amount of services in those elements of the continuum (modalities) for each community to be included.

- Describe how the State will overcome the barriers to accessing clinically appropriate care, using the SBIRT approach. Whenever possible, apply findings from recent literature and other information that demonstrates a thorough understanding of the issues faced in introducing SBIRT into the State's continuum of care. Include literature citations in Section E of your application.

- Describe the linkages to be developed between the participating specialist and community agencies for referrals, cooperation in case management, and information sharing.

- Provide a plan to make available training and technical assistance to sub-recipient communities, including information about SBIRT methods, training for staff in the community and specialist settings in carrying out SBIRT, and technical assistance to the overall project and its sub-recipients.[12] Include the plan, budget, budget justification and signed agreement in Appendix 3 of the application.

- Describe how the State will increase access and availability of services to a larger number of persons with Substance Use Disorders as a result of the award. State clearly the number of additional persons to be served for each year of the proposed cooperative agreement in each element of SBIRT (i.e., number of persons to be screened by each participating service provider, number of persons projected to receive Brief Intervention, number of persons expected to be referred for specialist assessment, number of persons to receive Brief Treatment) and the number of persons to receive clinically appropriate treatment in all other modalities within the system. Show that the targets are feasible and reasonable.

- Describe the expected outcomes of treatment (e.g., decreased drug use in those patients receiving services through SBIRT) and the means by which you determined these targets. Show that the targets are feasible and reasonable.

- Provide proposed per person costs per treatment episode based on the applicant's actual costs and projected costs over the 5-year project period for each modality. State whether or not these costs are within the acceptable ranges by treatment modality provided in the "Award Criteria" section. Discuss the reasonableness of the per person costs. If proposed costs exceed acceptable ranges, a detailed justification must be provided.

Section C: Project Organization, Management, and Staffing. 20 points

Project Management Plan. There will be three phases to the project: project planning and start-up; operations; and phase-out. For each phase of the project, provide a realistic management plan that describes the organizations and staff that will be involved in the project; presents their roles in the project; and addresses their relevant experience.

- Describe the structure, roles, and individual tasks to be performed to carry out the administrative and service delivery activities required to carry out (1) project administration, (2) policy and systems change, (3) training and technical assistance,[13] (4) monitoring sub-recipients' implementation of service delivery, data collection, and (5) reporting. Be sure to include a description of the role and involvements of the processes to be used to ensure significant involvement and oversight of the State's project by the Governor's Office, the Policy Steering Committee, the Project Director, the State Substance Abuse Authority (SSA), and other relevant agencies.

- Provide a staffing plan that includes the level of effort and qualifications of the Project

[12] The State may wish to consider subcontracting with the SAMHSA/CSAT funded Addiction Technology Training Centers (ATTCs) already working with its SSA or an in-state resource. A list of ATTCs, the States covered by each, and contact information is provided in Appendix A. If a subcontract with the ATTC, another academic institution, or a vender is used, the plan should include the cost for providing these activities as a separate budget component.

[13] Limited technical assistance on implementation, reporting, and monitoring progress toward meeting the SBIRT targets will be available if problems arise that cannot be resolved with the project's resources alone .

Director and other key personnel, such as the administrative staff providing oversight in the Governor's office, the clinical personnel in the community and specialist treatment agencies, trainers, and support personnel, specifying the agency that will employ these persons.

- Provide a description of the project organization, Statewide and for each sub-recipient community system. Include a Table of Organization with description of roles and relations, letters of support and commitment, outlining roles, funding, staff, services to be provided (if any), and referral relationships from participating and coordinating organizations in **Appendix 2**.

- Provide evidence that the existing and proposed staff have or will receive training to develop requisite experience and cultural sensitivity to provide services to the target population. Show evidence of the appropriateness of the proposed staff to the language, age, gender, sexual orientation, disability, literacy, and ethnic, racial, and cultural factors of the target population.

- Provide a performance schedule for task completion that includes a description of sequential relationships and approximate level of effort required per task (in person hours or full-time equivalents). Each task should be related to the project goals and objectives, as well as to management and staffing levels. Include a performance schedule and a task-sequencing chart in **Appendix 2**.

- **Phase I: Project Planning and Start-up.** Describe how the State will complete each of the start-up tasks specified above under Program Overview, Phase I: Project Planning and Start-up, that are necessary to implement the project. Describe how the Governor and the Policy Steering Committee will ensure that every component of the project is fully operational at the conclusion of Phase I and will monitor task accomplishments.

- **Phase II: Operations**. Describe the actions and timelines necessary for carrying out the systems change and service delivery activities described as part of the initial planning phase. Describe how the State will carry out the activities necessary to implement the project as identified above under Program Overview, Phase II: Operations.

- **Phase III: Phase-Out**. Describe the activities planned to make the transition from the SBIRT cooperative agreement funding to State and local control and funding in order to sustain the system changes achieved by the project.

Section D: Data Collection, Monitoring, and Reporting. 20 points

- Provide a plan for collecting, analyzing, interpreting, and reporting data on activities, costs, and outcomes, including the means by which the overall project and each sub-recipient will comply with GPRA requirements-- the collection of CSAT's GPRA Core Client Outcomes, and tracking and follow-up procedures.

- Although a formal local evaluation is not required, the applicant will be expected to monitor implementation of the project and its fidelity to their plan. Therefore, the plan should explain how the State intends to:

    - document the State-level and the sub-recipient community level and provider agency level activities, accomplishments, and outcomes associated with the SBIRT project;

- collect data in addition to the GPRA items, if any, using both quantitative and qualitative approaches as needed;

- measure changes in these activities and accomplishments over the life of the project;

- document what was actually done, what was learned, what barriers inhibited implementation, how such barriers were resolved, and what should be done differently in future projects;

- provide for obtaining consistent and uniform information across programs and sub-recipient sites Statewide; and

- provide regular feedback to the project managers, staff, and Policy Steering Committee to help the project improve operations and services. This feedback should include both process and outcome measures.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SAMHSA's Participant Protection Requirements

Part II of the PA/RFA provides a description of SAMHSA's Participant Protection Requirements and the Protection of Human Subjects Regulations.

The evaluation requirements as described in the "Project Narrative" section of this RFA are subject to the SAMHSA Participant Protection (SPP) provisions. However, applicants who propose to implement more in depth evaluation activities may be subject to the Federal provisions at 45 CFR Part 46 (Protection of Human Subjects). In accordance with these provisions, evaluation approaches designed to conduct the systematic collection of data on individual clients require review and approval by an Institutional Review Board (IRB). These requirements apply whether SAMSHA funds or funds from other sources are used to carry out the evaluation activities.

SAMHSA will place restrictions on the use of funds until all participant protection issues are resolved. Problems with participant protection identified during peer review of your application may result in the delay of funding. See Part II of the RFA for more information on participant protection.

You must address each element regarding participant protection in your supporting documentation. If any one or all of the elements is not relevant to your project, you must document the reasons that the element(s) does not apply.

This information will:

1. Reveal if the protection of participants is adequate or if more protection is needed.

2. Be considered when making funding decisions

Projects may expose people to risks in many different ways. In this section of your application, you will need to:

- Identify and report any possible risks for participants in your project.

- State how you plan to protect participants from those risks.

- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

Each of the following elements must be discussed:

Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse affects.
- Discuss risks that are due either to participation in the project itself, or to the evaluation activities.
- Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.
- Give plans to provide help if there are adverse effects to participants.
- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you do not decide to use these other beneficial treatments, provide the reasons for not using them.

Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other groups.
- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, or others who are likely to be vulnerable to HIV/AIDS.
- Explain the reasons for including or excluding participants.
- Explain how you will recruit and select participants. Identify who will select participants.

Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why it is required. For example, court orders requiring people to participate in a program.
- If you plan to pay participants, state how participants will be awarded money or gifts.
- State how volunteer participants will be told that they may receive services even if they do not complete the study.

Data Collection

- Identify from whom you will collect data; for example, participants themselves, family members, teachers, others. Describe the data collection procedure and specify the sources for obtaining data; for example, school records, interviews, psychological assessments, questionnaires, observation, or other sources. Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.
- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.
- Provide in **Appendix 4**, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

Privacy and Confidentiality:

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private. For example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  - Whether or not their participation is voluntary,
  - Their right to leave the project at any time without problems,
  - Possible risks from participation in the project,
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, and people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** get written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your **Appendix 5**, titled "Sample Consent Forms." If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data.

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

 Risk/Benefit Discussion:

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Special Considerations and Requirements

SAMHSA's policies, special considerations, and requirements related to grants and cooperative agreements are found in **Part II** of the RFA. The policies, special considerations, and requirements related to this program are:

- Population Inclusion Requirement
- Government Performance and Results Act
- Healthy People 2010
- Letter of Intent
- Intergovernmental Review (E.O.12372)
- SAMHSA Participant Protection

Appendix A
Resources for Implementing
Screening, Brief Intervention, Referral, and Treatment

Background

For purposes of this cooperative agreement, CSAT will not require a specific methodology for determining need, implementing systems change, or introducing SBIRT within its continuum of care. CSAT is not requiring specific protocols for carrying out the individual activities involved (viz., screening, brief intervention, referral, assessment, patient placement, and brief treatment). CSAT is not recommending a specific approach for developing collaboration among participating generalist and specialist providers. Rather, the applicant is required to describe and justify the strategies that will be implemented under the proposed cooperative agreement project and to describe the methods that will be used to assess need, eliminate barriers to access, and to carry out each of these activities. Wherever possible, the applicant should provide a description of any prior services or research projects on which their proposed approach is based.

In order to introduce some commonality in responses, we will present a brief overview of terminology and anticipated issues and provide illustrative references that can serve as resources for proposal development and project implementation. The resources and references provided are not presented as an inclusive listing that must be used in proposal preparation.

Terminology

From the scientific and policy perspectives, there have been two distinct approaches for responding to the social and health problems posed by drug abuse and addiction—the **clinical**, or diagnostic, approach and the **environmental**, or problems, approach (Gerstein and Green, 1993; Institute of Medicine, 1990). Over the years, drug policy has been shaped by these perspectives, shifting between punitive and rehabilitative strategies for reducing consumption of illicit drugs and the criminal behaviors associated with illicit drug use (Gerstein and Harwood, 1990).

The two perspectives have led to differences in how persons receiving and seeking treatment are characterized in developing resource allocation and financing schemes and create potential problems in consolidating funding streams to carry out SBIRT. The financing of treatment for substance use problems has differed from the rest of health care financing in part because the public sector through block and categorical grants has been the major payer for services (e.g., Horgan and Merrick, 2001). The shifting perspectives and orientations of the policymakers and legislators have also influenced these systemic perspectives (Gerstein and Harwood, 1990). Criminal justice funding, originally through the Federal Law Enforcement Administration block and categorical grant programs (more recently, the Office of Justice Programs and the Office of Juvenile Justice programs) created a public safety orientation, while funds from the poverty programs (e.g., the Social Services Block grant) created a welfare orientation. On the other hand, health insurance, like Blue Cross and Medicaid created a medical orientation. All three orientations have co-existed in the categorical grant and block grants directly targeted at treatment of substance use disorders, notably, the Substance Abuse Prevention and Treatment Block Grant, which attempts to integrate the perspectives, creating what has been labeled the mixed medical and social model orientation (IOM, 1990; Reader and Sullivan, 1992). For

example, Medicaid and other forms of health insurance require a clinical diagnosis and a determination of medical necessity for admission to treatment, while the Substance Abuse Prevention and Treatment Block Grant does not. The lack of common terminology has created problems in understanding who receives what services for treatment of substance use disorders with what outcomes (Coffey et al., 2001)

Developing the policies and data for studying utilization and designing policies to increase access to clinically appropriate treatment requires use of common terms with clear definitions, starting with identifying the conditiions for which treatment is needed. Diagnosis is the process of identifying and labeling specific diseases; diagnostic criteria for substance abuse and dependence disorders reflect the consensus of researchers and clinicians as to precisely which patterns of behavior or physiological characteristics constitute symptoms of these conditions. (Babor, 2001; NIAAA, 2002; NIDA, 1997) Agreement on diagnosis in this field is relatively new, and the definitions and techniques for establishing diagnoses are evolving. Having a consistent set of diagnostic criteria allows clinicians to plan treatment and monitor treatment progress; enables policymakers, and planners to ensure the availability of needed treatment resources in each community; helps health care insurers and other funders to decide whether treatment will be reimbursed; and allows patients access to medical insurance coverage.

As noted in the RFA, in accord with the National Drug Control Strategy's new approach to using diagnosis as the criterion for determining the size of the treatment gap, the need for treatment is discussed in terms of the categories used in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; 1994).[14] DSM-IV includes a category called "Substance Related Disorders" that is divided into two major subcategories, Substance Induced Disorders and Substance Use Disorders. The focus of this program is on that part of the continuum of care that addresses treatment of Substance Use Disorders and not the treatment of Substance Induced Disorders, namely Substance Intoxication and Substance Withdrawal. Patients manifesting signs of intoxication, withdrawal symptoms, and other physical problems that require emergency care or urgent action would be managed in other components of the generalist or specialist treatment systems, stabilized and medically cleared before being screened for presence of a Substance Use Disorder (VHA/DoD, 2001).

Substance Use Disorders are further differentiated by type of drug primarily involved (e.g., amphetamine, alcohol, cocaine, marijuana/cannabis). DSM-IV is the diagnostic approach primarily used in this county for determining treatment eligibility, developing substance-specific treatments, and conducting epidemiological and clinical research.

Based on the DSM-IV, *Substance Abuse Disorder* is characterized by the presence of social or health-related problems related to the person's consistent pattern of substance use. *Substance* D*ependence* Disorder is characterized by a cluster of recognizable symptoms, including physical withdrawal, loss of control over use episodes, and continued use of substance despite knowledge of having a physical or psychological problem that is likely caused by substance.

[14] For a discussion of the methodology change, see Epstein, 2002. Substance Dependence, Abuse, and Treatment: Findings from the 2000 National Household Survey on Drug Abuse, Appendix C: Measurement of Dependence, Abuse, Treatment, and Treatment Need.

The World Health Organization has also developed diagnostic criteria for the purpose of compiling statistics on all causes of death and illness, including those related to substqance abuse or dependence. These criteria are published as the *International Classification of Diseases* (ICD). In the current revision, ICD-10, substance dependence is defined in a way that is similar to the DSM-IV. The diagnosis focuses on an interrelated cluster of psychological symptoms, such as craving; physiological signs, such as tolerance and withdrawal; and behavioral indicators , such as the use of alcohol to relieve withdrawal discomfort. However, in a departure from the DSM-IV, rather than include the category "abuse," ICD-10 includes the concept of "harmful use." This category was created so that health problems related to alcohol and other drug use would not be underreported. Harmful use implies alcohol or drug use that causes either physical or mental damage in the absence of dependence (Babor, 2001). The ICD classification approach has served as the basis for much of the research underlying the use of brief interventions.

Review of the literature and discussions with practitioners and State Substance Abuse Authorities (SSAs) established that, while most of the research establishing the effectiveness of this approach has focused on alcohol use problems and disorders and has used the **problems** approach rather than the **clinical** approach, there is an emerging body of research and clinical experience that supports use of the SBIRT approach for nondependent persons who are experiencing problems related to the use of illicit drugs, particularly for marijuana use disorders (e.g., Stephens et a., 1994; Samet et al., 1996; Sullivan et al., 1997: Babor et al. 2002; Barry, 1999; Bernstein et al., 1997; Zweben and Fleming, 1999; Roffman, 1999; Dennis, et al. 2002a and b; Conrod et al., 2000; Baker et al. 2001; Babor, et al., 2002; Blow, 1999: Fleming, 2002; Kelso, 2002; WHO ASSIST Working Group, 2002).

While the effort to develop brief interventions for nondependent drug users has not been as extensive as that for persons with alcohol problems, there have been several precedents. Early in the effort to develop a national drug strategy, the Treatment Subcommittee of the Cabinet Committee on Drug Abuse Prevention, Treatment and Rehabilitation in responding to pressure on the limited availability of treatment slots, recommended the establishment of distinct, lower cost "Alternative Educational Programs" (Bloom, 1977). These "alternatives to treatment or incarceration were recommended as the vehicle for "treating the casual and recreational marijuana users" who were being "inappropriately" referred to drug abuse treatment centers, most often by the criminal justice system through diversion efforts (Domestic Council Drug Abuse Task Force, 1975). The stated goal was to allow the specialty drug abuse treatment system to focus on the "abusers of high risk drugs." Marijuana, at that time, was considered a low risk drug.

The model programs presented by NIDA were short-term, inexpensive educational programs with both didactic presentations and group discussions. These alternative educational programs became the forerunners of many of the intervention programs that still exist in the gray area between prevention and treatment—often having statutory authorization as diversion programs.

There is evidence that a number of States have already begun to introduce protocols for screening and brief intervention for both alcohol and drug use problems and disorders into their

continuum of care (e.g., New York OASAS, 1996; Harrison et al., 1996; Hartwell et al., 1996: Kroutil et al., 1997).[15] Yet, in contrast to more traditional treatment services, early intervention services are often not specifically defined or regulated (IOM, 1990; Klitzner, et al., 1992). For purposes of this announcement, early intervention services (brief interventions) are those treatment procedures designed for persons who are exhibiting some problems associated with alcohol or other drug use but whose problems are not deemed serious enough to warrant treatment within a specialist setting (i.e., those nondependent persons at high risk of or already diagnosed with a substance abuse disorder). Early intervention services are sometimes identified as pre-treatment interventions (Blow, 1998) or clinical preventive services (U.S. Preventive Task Force, 1998) or indicated preventive interventions (Haggerty and Mrazek, 1994). The goal of early intervention is to prevent the problems from becoming more serious, and to promote total abstinence from alcohol and other illegal drugs. Early intervention could include an assessment of substance use and related problems, individual counseling provided by a health care practitioner, or participation in school-based or community-based educational or counseling programs designed to deter further substance use and promote healthier alternatives.

CSAT's approach to early intervention through screening, brief intervention, and brief treatment is to be differentiated from the parallel efforts within CSAP. While both approaches use the same technologies, CSAP funded early intervention programs address persons who are at high risk of developing a substance use disorder through indicated preventive interventions,[16] while CSAT funded programs address persons who would achieve a diagnosis of substance use disorder. CSAP and CSAT are working together to jointly assist the States in implementing the entire continuum of care as presented in the Institute of Medicine report, **Reducing Risks for Mental Disorders** as modified by CSAT for the National Treatment Plan (CSAT, 2000). The IOM report recommends that the traditional public health classifications of primary, secondary, and tertiary prevention be replaced by new classification system for the continuum of care:

> **Universal preventive interventions:** targeted to the general public or a whole population group that has not been identified on the basis of individual risk. The intervention is

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[15] A number of other States have included similar characterizations for differentiating intervention and treatment in their rules or planning efforts (e.g., Louisiana, Minnesota, Florida, North Carolina, Connecticut, Vermont, Washington). For example, South Dakota has defined its approach as part of the regulations governing licensure of treatment facilities: "A facility that provides Early Intervention and Outpatient Services is a nonresidential facility that provides direct supportive client contact, indirect or collateral client contact, community information and liaison services. The program also provides formally planned counseling services to those persons harmfully affected by alcohol or drugs and who have been determined not to be in need of or accepting of structured outpatient or residential services." http://legis.state.sd.us/rules/rules/6716A.htm#67:16:11:03.04. Apparently some States (e.g., Florida) define intervention as both a treatment and non-treatment activity.

[16] The CSAP strategy for this activity had previously been designated as "Problem Identification and Referral Programs" that may screen, identify and serve persons who could be diagnosed as having a substance use disorder as well as those individuals who could be classified as non-users, at risk users, and at high risk users. Many, if not all, of the programs are operated as primary prevention programs and use a problem count (e.g., the AUDIT) to classify those persons served rather than a clinical diagnosis. This difference in perspectives leads them to intervene (i.e., provide advice and feedback; counsel with) persons who may be in either an at risk category or with a diagnosis, without always clearly differentiating between the two classes. In clinical settings, when delivered by licensed health practitioners, such activities would be considered a clinical preventive service.

desirable for everyone in that group. Universal interventions have advantages in terms of cost and overall effectiveness for large populations.

Selective preventive interventions: targeted to individuals or a subgroup of the population whose risk of developing a mental or substance use disorder is significantly higher than average. The risk may be imminent or it may be a lifetime risk. The basis may be biological, psychological, or environmental.

Indicated preventive interventions: targeted to high risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing a mental or substance use disorder, or biological markers indicating predisposition for a disorder, but who do not meet accepted clinical diagnostic criteria at the time.

Treatment interventions: therapeutic services designed to reduce the length of time a disorder exists, halt its progression of severity, or if not possible, increase the length of time between acute episodes. There are two categories of treatment interventions: (1) case finding; and (2) standard treatment for the known disorders, which includes interventions to reduce the likelihood of future co-occurring disorders.

Maintenance interventions: services, generally supportive, educational, and/or pharmacological in nature, provided on a long-term basis to individuals who have met DSM-IV diagnostic criteria, are considered in remission, and whose underlying illness continues. The two components of maintenance interventions are (1) patient's compliance with long-term treatment to reduce relapse and recurrence and (2) the provision of after-care services, including rehabilitation. (Haggerty and Mrazek, 1994:23-24)

Rather than negating the public health approach to defining primary, secondary, and tertiary prevention as some have held, the IOM model can be seen as complementary, expanding the public heath approach. The newer IOM model can be seen as actually further differentiating the public health construct of primary prevention into the categories of universal, selected, and indicative interventions, and the public health constructs of secondary and tertiary prevention into the categories of treatment and maintenance, respectively. The early intervention activities overlap the boundaries between primary prevention (indicated prevention) and secondary prevention (case finding).

In filling out the treatment portion of a State's continuum of care, the purpose of screening for substance use problems is to identify those persons who should receive either a brief intervention for a Substance Abuse Disorder or referral for additional screening and assessment to establish whether more intensive treatment for a Substance Use Disorder (SUD) is needed. The persons screened *may* or *may not* meet the DSM-IV criteria for a substance abuse or dependence disorder (American Psychiatric Association, 1994). If they do not, but are deemed to be at risk users, than the same technology is employed as a clinical preventive service (or indicated preventive intervention). In practice, the activities are the same. However, the distinction is important for developing financing policies, for conducting epidemiological research and for tracking treatment access, appropriateness, utilization, and effectiveness.

Since diagnosis has not always been used as a criterion for admission to treatment in publicly funded treatment programs, States and service providers will need to introduce and agree upon a uniform approach to diagnosis as part of their implementation of this program and efforts to provide sustained funding for SBIRT, particularly through public and private health insurance mechanisms.

Integrating the Diagnostic and Problems Approaches

As noted, the DSM-IV term *substance use disorders* can be used to refer to a range of substance-related problems that require treatment. A spectrum of substance use disorders, from least to most serious, which encompasses the problems approach used in developing screening protocols for the use of brief interventions might be represented as follows:

Problem Use or At Risk Use — Substance Abuse Disorder — Substance Dependence Disorder

In general, *problem or at-risk use* means use that exceeds an established threshold. The threshold may be defined in different ways depending on the source, the population, and other local conditions. The majority of work for developing such classifications in order to identify persons who could benefit form a brief intervention has been carried out for alcohol use problems and disorders. For example, the WHO manuals for introducing screening and brief intervention into primary care present general guidelines for assigning "risk levels" based upon AUDIT scores, that conform the spectrum above and lay out a spectrum of intervention and treatment responses.

Table 1: AUDIT Guidelines for Determining Intervention Strategy[17]

Risk Level	Intervention	Audit Score
I	Education	0-7
II	Simple Advice	8-15
III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

The risk levels are used as a basis for making clinical judgments to tailor interventions to the particular conditions of individual patients, assuming that higher AUDIT scores are generally indicative of more severe levels of risk and problems or dependence. The guidelines are to serve as a starting point for an appropriate intervention. If a patient is not successful at the initial level

[17] Based on Babor and Higgins-Biddle (2001) Brief Intervention For Hazardous And Harmful Drinking: A Manual for Use in Primary Care, Box 2, p.12

of intervention, than the protocol calls for follow-up to develop a plan to step the patient up to the next level of intervention. (Babor and Higgins-Biddle, 2001; Babor et al., 2001)

This approach is similar to that used for other screening tests, such as the Drug Abuse Screening Test (DAST).

Table 2: DAST Guidelines for Determining Intervention Strategy[18]

Score	***Degree of Problems Related to Drug Abuse***	***Suggested Action***
0	No Problems Reported	None At This Time
1-2	Low Level	Monitor, Reassess At A Later Date
3-5	Moderate Level	Further Investigation
6-8	Substantial Level	Intensive Assessment

These classification systems reflect the different patterns of drug use consumption and problems that call for differential societal responses that reflect differences in the drug (substance) used, the history, frequency, and amount used, as well as the existence and severity of associated physical, emotional, and social consequences of use. The Institute of Medicine committee that carried out a Congressionally mandated study of the evolution, effectiveness and financing of public and private drug treatment systems (Gerstein and Harwood, 1990) described a four level classification system reflecting these patterns that was a starting point in developing their initial estimates of the need for treatment, a model that was adapted for creating national estimates of the treatment gap. Table 3 depicts individual drug use patterns and interventions associated with each pattern of use. Each stage of use elicits a different type of societal response. The definitions for the categories are:

> **Use**: Low or infrequent doses: experimental, occasional, "social." Damaging consequences are rare or minor.
>
> **Abuse**: Higher doses and/or frequencies: sporadically heavy, intensive. Effects are unpredictable, sometimes severe.
>
> **Dependence**: High, frequent doses: compulsion, craving, withdrawal. Severe consequences are very likely.

Table 3: Individual Drug Use Patterns and Intervention Strategies[19]

Stage	**Category of Use**	**Use Pattern**	**Reason**	**Consequences**	**Societal Responses**

[18] Based on Skinner HA (1982).
[19] Based on Figure 3-1. A model of individual drug history, Gerstein and Harwood (1990:61).

	Abstinence				Prevention programs	
Early/light	Use	Low or infrequent doses	Experimental, occasional, "social"	Minor	Prevention programs	Mild sanctions
Late/heavy	Abuse	Higher doses and/or frequencies	Sporadically heavy	Unpredictable, sometimes severe		
Late/heavy	Dependence	High, frequent doses	Compulsion, craving, withdrawal	Severe	Treatment programs	Severe sanctions

In the SBIRT approach, all persons are first screened and referred to the appropriate sector (community generalist, non-specialty or specialty) for intervention or treatment. Persons with a mild or moderate level of substance use problems would most often be offered a brief intervention in the non-specialty primary health care, criminal justice, educational, employment, or social service setting. Referral to intensive treatment in the specialty sector would be made only for those whose life situation is so unstable that prognosis is poor without specialty treatment or for those who fail to respond to an initial brief intervention--the stepped care approach (Sobell and Sobell, 1999, 2000).

Persons with substantial or severe problems would be referred from screening to specialty sequential assessment and treatment where problem and personal assessment would lead to assignment to more differentiated types of treatment modalities and levels of care, using a formal set of patient placement criteria.

Recent efforts have attempted to integrate the problem and diagnostic approaches, using both the research literature and clinical experience to refine the methods for screening, referring, and treating person's based on these concepts (e.g., ASAM, 2000; APA, 1994; VHA/DoD, 2001). A possible model for this integration is presented in Table 4. The model also attempts to integrative the public health and IOM models for defining the continuum of care.

Table 4: Integrating the Problem and Diagnostic Perspectives--A Possible Model

Problems	**Risk Category or**	**Intervention Strategy**	**Exposures\ Sessions**	**Follow-up Suggested: Track: use, risk factors,**

	Diagnosis			**and problems**
No problems	No risk Or low risk	Universal prevention	Variable	Periodic re-screen: every year
Mild problems	At low risk	Clinical preventive service Selective prevention-brief advice	1-2	Periodic re-screen: every year
Moderate problems	At high risk	Clinical preventive service Indicated prevention Brief advice Brief intervention	1-2	Periodic re-screen every 6 months for 3 years, every year if no relapse
Moderate problems	Substance Abuse Disorder (DSM-IV, Axis I)	Brief advice Brief intervention Brief treatment	1-2 1-5 6-20	Periodic re-screen and booster session: every 3 months for 2 years, every 6 months for 2 years, every year if no relapse
Substantial problems	Substance Dependence Disorder (DSM-IV, Axis I)	Sequential assessment; match to clinically appropriate consumption and quality of life treatment strategies	21-60+	Periodic re-screen: every 3 months for 2 years, every 6 months for 2 years, every year if no relapse
Severe problems	Substance Dependence Disorder (DSM-IV, Axis I)	Sequential assessment; match to clinically appropriate consumption and quality of life treatment strategies	Variable; Based on individual response to treatment	Periodic re-screen: every 3 months for 2 years, every 6 moths for 2 years, every year if no relapse

Using either the problems approach or the clinical approach, it is well recognized that within each community there is a spectrum of persons with substance use-related problems. In keeping with recent summaries of the international research literature, it is estimated that the majority of adults are either abstainers or light or moderate nondependent users of alcohol or illicit drugs, and experience either no problems or mild or moderate substance use-related problems (estimated at approximately 75%). There is a small but often highly visible minority of heavy, dependent users with major substance-related problems (estimated at approximately 5%). In between these extremes, there is a sizeable group of persons (20%) who may be drinking or using illicit drugs substantially or heavily and who have encountered substantial or severe problems related to their substance use. The concepts have been more difficult to address for illicit drugs, since any use could be seen as "abuse" because of potentially legal consequences.

As will be noted below, treatment is not necessarily the best societal response for these nondependent persons, but a brief intervention, early in their use career may well be.

These findings suggest that the continuum of care in each community must include a spectrum of primary, secondary, and tertiary prevention responses that parallels the spectrum of problem associated with use and that the diagnostic and problems approaches must be reconciled to ensure introduction of evidence based clinical protocols (NIDA, 1999). Research on effectiveness of specific approaches continues, but there is sufficient evidence available to lead to the policy conclusion that more widespread SBIRT efforts will decrease the medical and social costs of illicit drug use.

Using a method similar to that employed by Skinner and his colleagues in the original development of screening for establishing brief interventions as a valid technology, persons can be classified into four graded categories of drug and alcohol use problems, each of which should lead to a different treatment or intervention strategy being employed and to a different set of resource requirements (See Table 4.):

> **Mild level of substance use problems**. Use is light or moderate; symptoms are rated as mild or moderate; dependence is probably not present or, if present, is psychological rather than physical; life problems related to use are rated as absent, mild, or moderate.
>
> **Moderate level of substance use problems**. Use is medium, substantial, or heavy; symptoms are rated as moderate; psychosocial problems related to use are likely and rated as moderate; psychological dependence may still be characteristic, but there are increasing signs of physical dependence, such as withdrawal symptoms; related life problems are rated as mild and/or moderate.
>
> **Substantial level of substance use problems**. Use is substantial or heavy; symptoms are rated as substantial; physical dependence is likely; physical disorders, mental disorders, and psychosocial problems related to substance use are rated as moderate and/or substantial.
>
> **Severe level of substance use problems**. Use is heavy; symptoms are rated as substantial and/or severe; physical dependence is highly pronounced; life problems are rated as substantial and/or severe; serious physical disorders and mental disorders related to use, such as liver disease, are likely.

As presented in Table 4, persons can also be classified as either nondependent users (those with mild or moderate problems) or dependent users (those with substantial and severe problems) and also be diagnosed as meeting the clinical criteria for a DSM-IV abuse disorder or a dependence disorder. The act of diagnosis shifts the nature of the services from prevention to treatment.

In measuring the size of the treatment gap and developing strategies to increase access to clinically appropriate treatment, ONDCP and SAMHSA want the States to focus on the resources needed for improved screening, intervention, referral and treatment for substance use

disorders in order to increase the resources devoted to identifying and intervening with the nondependent users as part of the generalist health care system.
States should be able to provide for a similar linkage between whatever classification system your State is using and the DSM-IV categories in the protocol.

Resources for Implementing Screening

In health care, screening refers to a process designed to identify people who have, or who are at risk of having, an illness or disorder. The purpose of screening is to target persons for treatment, so as to reduce the long-term morbidity and mortality related to the condition. In addition, by intervening early and raising the individual's level of concern about the risk factors and substance-related problems, it is expected that screening for drug and alcohol problems in community settings can itself reduce subsequent use.

Two types of screening procedures are typically used. The first type includes self-report questionnaires and structured interviews; the second, clinical laboratory tests that can detect biochemical changes associated with excessive alcohol consumption or illicit drug use.

There are a variety of screening instruments available. As noted, the majority of studies and implementation efforts have focused on screening for alcohol problems, with the CAGE and the AUDIT being the most commonly used screening tools. The DAST has also been used in conjunction with the AUDIT in several projects, where there has been an effort to implement this approach for persons with or at risk of a Substance Use Disorder. Several new instruments have been developed, but not yet rigorously tested to assess harmful use of either alcohol or drugs (e.g., the CAGE-D, the ASSIST, the TCUDS, the GAIN-QS, the PDES).

> Brown, RL and Rounds LA. 1995. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*, 94, 135-140.
>
> Brown R, Leonard T, Saunders LA, et al. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, 151-160.

A bibliography containing descriptions and evaluations of various interview, questionnaire, and laboratory test screening approaches is available from Project Cork

> Project Cork. 2002. *CORK Bibliography: Screening Tests.* 2001-2002, 58 Citations. http://www.projectcork.org/bibliographies/data/Bibliography_Screening_Tests.html

Screening instruments have been developed or modified for use with different target populations, notably adolescents, offenders within the criminal justice system, and welfare recipients, women, and the elderly. Several have been translated into other languages and have been evaluated for cultural sensitivity. Again, CSAT is not requiring a specific instrument or protocol, but choice of instruments or laboratory tests must be justified.

It is well recognized that screening instruments used with adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical settings. One example of a

brief substance abuse screening instrument recently developed specifically for use with adolescents is the CRAFFT test.

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. 2002. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med*. 156(6): 607-14.

Additional screening tests and procedures targeted at adolescents, including the PDES and the GAIN-QS, are described in these publications:

Winters KC. 1992. Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addict Behav*. 17(5): 479-90.

Winters KC. 1999. **Screening and Assessing Adolescents For Substance Use Disorders**. Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.

Winters KC. 1999. **Treatment of Adolescents With Substance Use Disorders.** Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA*)* 99-3283.

Winters KC. 2001. Assessing adolescent substance use problems and other areas of functioning: State of the art. In: PM Monti, SM. Colby, and TA. O'Leary (eds). **Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions**. New York, Guilford Publications, Inc., pp. 80-108.

Dennis ML 1998. **Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation**, (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications.
http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Martino S, Grilo CM, and Fehon DC 2000. Development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors* 25(1): 57-70.

Screening tests and procedures targeted at the elderly are described in these publications:

Blow, F.C. Consensus Panel Chair. 1998. **Substance Abuse Among Older Adults**. Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.

Blow FC and Barry KL. 1999-2000. Advances in alcohol screening and brief intervention with older adults. *Advances in Medical Psychotherapy*. 10:107-124

Screening tests and procedures targeted at persons in the criminal justice system are described in these publications:

Inciardi JA Consensus Panel Chair 1994. **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.** Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076

Peters, RH, Greenbaum, PE, Steinberg, ML, Carter, CR, Ortiz, MM, Fry, BC, Valle, SK. 2000. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal Substance Abuse Treatment*: 18(4): 349-58.

Simpson DD. 2001. Core set of TCU forms. Fort Worth: Texas Christian University, Institute of Behavioral Research. www.ibr.tcu.edu.

Efforts are also ongoing to develop methods for screening within the dual diagnosis population:

Maisto SA, Carey MP, Carey KB, Gordon CM, and Gleason JR. 2000. Use of the AUDIT and the DAST-10 to identify alcohol and drug use disorders among adults with a severe and persistent mental illness. *Psychological Assessment* 12(2): 186-192.

Resources for Implementing Brief Interventions and Brief Treatments

There are now a variety of approaches that have been labeled as Brief Interventions (BI) and Brief Treatments (BT). Examples of approaches that address specific drugs are the Cannabis Youth Treatment protocol and the Adult Marijuana Treatment protocol, developed through CSAT funded testing of models originally developed through NIDA and NIAAA research.

Brief intervention and brief treatment strategies range from relatively unstructured advice-giving, to counseling and formalized feedback, to formal structured manuals for the number, duration, frequency, and content of sessions. Many of the protocols are based on behavioral self-control training, motivational interviewing, and cognitive-behavioral psychotherapy.

One of the most extensive efforts to attempt to conceptualize and differentiate Brief Interventions and Brief Treatments (and Long Term Treatments) was CSAT's TIP 34: **Brief Interventions and Brief Therapies for Substance Abuse**, published in 1999. The Consensus Panel for CSAT TIP #34 describes the two activities as follows:

Brief Intervention

Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

Brief Treatment (Therapy)

Brief treatment (therapy) is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually is the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus of this TIP is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client.

In distinguishing between Brief Intervention and Brief Treatments, Zweben and Fleming (1999) characterize Brief Interventions as a low-cost, effective treatment alternative for alcohol and drug problems that use time-limited, self-help and preventive strategies to promote reductions in the case of nondependent clients, and in the case of dependent clients to facilitate their referral to specialized treatment programs. The primary goal in all cases is to increase motivation for behavior change. Brief interventions do not teach specific cognitive or behavioral skills, nor do they attempt to change a client's social environment.

Some researchers, practitioners, and policy analysts have suggested that the differentiation should be made on the basis of the number of sessions, with Brief Intervention typically lasting 1-3 sessions, not more than 5 sessions, and Brief Treatment typically consisting of 6 or more sessions but not more than 20 sessions. Others have limited Brief Interventions to only 1 or 2 sessions and Brief Treatments to no more than 6 sessions.

Brief interventions and brief therapies may be thought of as elements on a continuum of care, but they can be distinguished from each other according to differences in outcome goals. Interventions are generally aimed at motivating a client to perform a particular action (e.g., to enter treatment, change a behavior, think differently about a situation), whereas therapies are used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance abuse).

A bibliography containing descriptions and evaluations of various brief intervention and brief treatment approaches is available from Project Cork

> Project Cork. 2002. *CORK Bibliography: Brief Treatment in Substance Abuse*: *2000-2002*, 78 Citations.
> http://www.projectcork.org/bibliographies/data/Bibliography_Brief_Treatment.html

Resources for Protocol Development

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. Examples of protocols, screening instruments, and methods for carrying out activities required to implement the SBIRT program can also be found in several Treatment Improvement Protocols (TIPS) published by CSAT. TIPS can be accessed on the internet through the Treatment Improvement Exchange at: http://www.treatment.org/Externals/tips.html

Barry KL Consensus Panel Chair. 1999. **Brief Interventions And Brief Therapies for Substance Abuse.** Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99-3353.

Blow FC. Consensus Panel Chair. 1998. **Substance Abuse Among Older Adults**. Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.

Miller WR. Consensus Panel Chair. 1999. **Enhancing Motivation for Change in Substance Abuse Treatment.** Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99-3354.

Rostenberg PO. Consensus Panel Chair. 1995. **Alcohol and Other Drug Screening of Hospitalized Trauma Patients.** Treatment Improvement Protocol (TIP) Series 16. DHHS Publication No. (SMA) 95-3039.

Siegal H.A Consensus Panel Chair. 1998. **Comprehensive Case Management for Substance Abuse** Treatment. Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222.

Sullivan E., Fleming, M. Consensus Panel Co-Chairs. 1997. **A Guide to Substance Abuse Services for Primary Care Clinicians**. Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97-3139.

Winters KC. Consensus Panel Chair. 1999. **Treatment of Adolescents With Substance Use Disorders**. Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA*)* 99-3283.

An excellent example of a protocol that can guide implementation of a systematic approach to expanding the continuum of care is that developed by the VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense (2001). Electronic copies of the guideline are available from: Office of Quality and Performance web site: http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm.

The VA/DoD guideline consists of five modules that address inter-related aspects of care for patients with Substance Use Disorders. Module A, Assessment and Management in Primary Care, provides a summary of the evidence base for the use of screening and brief interventions and outlines pathways for referral to specialty treatment.

Module A:	**Assessment and Management in Primary Care** includes screening, brief intervention, and specialty referral considerations.
Module C:	**Care Management** emphasizes chronic disease management for patients unwilling or unable to pursue rehabilitation goals.
Module P:	**Addiction-Focused Pharmacotherapy** addresses use of currently approved medications as part of treatment for alcohol and opioid dependence.
Module R:	**Assessment and Management in Specialty Care** focuses on patients in need of further assessment or motivational enhancement or who endorse rehabilitation goals.
Module S:	**Stabilization** addresses detoxification and pharmacological management of withdrawal symptoms.

The VA/DOD Guidelines and the TIPS are to presented here as examples that may or may not fit a particular State's definition of its continuum of care. New York State has developed its own procedures, as may have other States:

New York State Office of Alcoholism and Substance Abuse Services (New York OASAS). 1996. **Changing Directions: Reference Manual for Early Intervention Services.** Albany NY: New York OASAS.

Brief Intervention Manuals

As noted in the RFA, CSAT has recently supported development and evaluation of manualized brief intervention and brief treatment strategies for adolescents and adults with marijuana use disorders that can be utilized.

Manuals in the Cannabis Youth Treatment (CYT) Series include:

> Sample S., and Kadden R. 2002. **Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions**. Cannabis Youth Treatment (CYT) Series, Volume 1. http://ncadi.samhsa.gov/govpubs/bkd384/
>
> Webb C, Scudder M, Kaminer Y, and Kadden R 2002. **The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users**. Cannabis Youth Treatment (CYT) Series, Volume 2. http://ncadi.samhsa.gov/govpubs/bkd385

Hamilton NL., Brantley LB, Tims FM, Angelovich N., and McDougall B. 2002. **Family Support Network for Adolescent Cannabis Users**. Cannabis Youth Treatment (CYT) Series, Volume 3. http://ncadi.samhsa.gov/govpubs/bkd386/cyt3.pdf

Godley SH., Meyers RJ, Smith JE, Karvinen T, Titus JC, Godley MD., Dent G, Passetti L, and Kelberg P. 2002. **The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users.** Cannabis Youth Treatment (CYT) Series, Volume 4.

Liddle, HA. 2002. **Multidimensional Family Therapy for Adolescent Cannabis Users**, Cannabis Youth Treatment (CYT) Series, Volume 5.

These efforts build on prior research done under the auspices of the National Institute on Drug Abuse (NIDA), the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the World Health Organization (WHO), which have has also issued several manuals that can also serve as resources in project development:

Babor TF and Higgins-Biddle JF. 2001**. Brief Intervention For Hazardous And Harmful Drinking: A Manual for Use in Primary Car**e. Geneva: World Health Organization. WHO/MSD/MSB/01.6b.

Babor TF, Higgins-Biddle JC, Saunders JB, and Monteiro, MG. 2001. **AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care. Second Edition**. Geneva: World Health Organization. WHO/MSD/MSB/01.6a.

Carroll KM 1998. **A Cognitive-Behavioral Approach: Treating Cocaine Addiction**. National Institute on Drug Abuse Therapy Manuals for Drug Addiction, Manual 1, NIH Publication 98-4308.

Miller WR, Zweben A, DiClemente CC, et al. 1992. **Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence.** NIAAA Project MATCH Monograph Series Vol. 2. DHHS Publication No. (ADM) 92-1894.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) 1995. **The Physicians' Guide to Helping Patients With Alcohol Problems**. NIH Publication No. 95-3769.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2003. **Helping Patients with Alcohol Problems: A Health Practitioner's Guide**. NIH Publication No. 03-3769. Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.

Roberts LJ and McCrady BS 2002. **Alcohol Problems in Intimate Relationships: Identification and Intervention - A Guide for Marriage and Family Therapists**. Rockville MD: National Institute on Alcohol Abuse and Alcoholism.

Resources for Analyzing Barriers and Implementing Systems Change

Additional resources for analyzing barriers to access and linkage between the generalist and specialist agencies and devising policy changes are provided by CSAT Technical Assistance Publications (TAPs). TAPS are publications, manuals, and guides developed by CSAT to offer practical responses to emerging issues and concerns in the substance abuse treatment field. Each TAP is developed by an expert who has had firsthand experience with the topic. TAPS can be accessed on the internet through the Treatment Improvement Exchange at: http://www.treatment.org/Taps/

TAPS that may be useful resources include:

Crowe AH. and R Reeves. 1994. **Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination**. Technical Assistance Publication (TAP) Series 11.DHHS Publication No. (SMA) 94-2075.

Hansen C. 1995. **Forecasting the Cost of Chemical Dependency Treatment Under Managed Care: The Washington State Study**. Technical Assistance Publication (TAP) Series 15. DHHS Publication No. (SMA) 95–3045).

Moss S. 1998. **Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers.** CSAT Technical Assistance Publication Series, Number 22. http://www.treatment.org/taps/tap22/TAP22TOC.htm

Other publications that can be used to understand development of cost estimates, financing analyses, and systems change strategies are.

Broskowski A and Smith S. 2001. **Estimating the Cost of Preventive Services in Mental Health and Substance Abuse Under Managed Care**. Substance Abuse and Mental Health Services Administration. http://www.mentalhealth.org/publications/allpubs/SMA-02-3617R/appendix.asp

Denmead G and Rouse BA (eds) 1994. **Financing Drug Treatment Through State Programs.** Services Research Monograph No1. NIH Publication No.94-3543. Rockville MD: National Institute on Drug Abuse.

Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL 2000. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Med Care* 38(1): 7-18.

French MT, et al. 2001. Using the drug abuse screening test to analyze health services utilization and cost for substance users in a community-based setting (DAST-10). *Substance Use and Misuse* 36(6-7): 927-46.

Fortney J and BM Booth. 2001. Access to substance abuse services in rural areas. In Galanter M (ed). **Recent Developments in Alcoholism: Volume 15. Services Research in the Era of Managed Care**. New York: Plenum Press, pp. 177-197.

Horgan CM. and EL Merrick. 2001. Financing of substance abuse treatment services. In Galanter M (ed) Recent Developments in Alcoholism: Volume 15. **Services Research in the Era of Managed Care**. New York: Plenum Press, pp. 229-252.

Libertoff K 1999. **Fighting for Parity in an Age of Incremental Health Care Reform**. Montpelier VT: Vermont Association for Mental Health.

McCrady BS and Langenbucher JW. 1996. Alcohol treatment and health care system reform. *Archives of General Psychiatry*, 53(8): 737-746.

National Association of State Alcohol and Drug Abuse Directors (NASADAD). 2002. **Identification and Description of Multiple Alcohol and Other Drug Treatment Systems.**

Physician Leadership on National Drug Policy (PLNP). 2000. **Position Paper on Drug Policy.** Providence RI: Brown University Center for Alcohol and Addiction Studies http://www.caas.brown.edu/plndp/Resources/researchrpt.pdf

Weisner C. 1992. The Merging of Alcohol and Drug Treatment: A Policy Review. *Journal of Public Health Policy* 13(1): 66-80.

Weisner C, Mertens J, Parthasarathy S, Moore C, and Lu Y. 2001. Integrating Primary Medical Care with Addiction Treatment: A Randomized Controlled Trial. *Journal of the American Medical Association* 286(14): 1715-1723.

Weisner C, and Schmidt L. 1993. Alcohol and drug problems among diverse health and social service populations. *American Journal of Public Health* 83:824-829.

Weisner C and Schmidt L 2001. Rethinking access to alcohol treatment. In Galanter M. (ed). **Recent Developments in Alcoholism: Volume 15. Services Research in the Era of Managed Care**. New York: Plenum Press, pp. 107-135.

Weisner C, Matzger H, Tam T, and Schmidt L. 2002. Who goes to alcohol and drug treatment? Understanding utilization within the context of insurance. *J. Stud. Alcohol* 63**:** 673-682.

Zarkin GA, Galinis DN, French MT. Fountain DL, Ingram PW, and Guyett JA. 1995. Financing strategies for drug abuse treatment programs. 1995. Journal of *Substance Abuse Treatment*. 12(6): 385-399.

Additional articles that address strategies for overcoming resistance and implementing systems change include:

Babor TF and Higgins-Biddle JF. 2000. Alcohol screening and brief intervention: dissemination strategies for medical practice and public health. *Addiction.* 95(5): 677-686.

Lock CA and Kaner E 2000. Use of Marketing to Disseminate Brief Alcohol Intervention to General Practitioners: Promoting Health Care Interventions to Health Promoters. *Journal of Evaluation in Clinical Practice*. 6(4): 345-357.

Fleming MF. 2002. Screening, Assessment, and Intervention for Substance Use Disorders in Settings. In: ***Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders*.** Providence RI: Association for Medical Education and Research in Substance Abuse (AMERSA). http://www.projectmainstream.net/mainstream/supportdata/part1.pdf

Physician Leadership on National Drug Policy (PLNP). 2002**. Project Vital Sign.** Providence RI: Brown University Center for Alcohol and Addiction Studies.

The emphasis in this RFA is on expanding the State's continuum of care to include screening, brief intervention, referral, and brief treatment (SBIRT) in general medical settings. It is recognized that SBIRT activities are being, or could be, carried out in non-medical community settings (viz., student assistance programs, employee assistance programs, and welfare offices, drug courts, senior citizen centers).

While most of the research has been focused on screening in primary care medical settings, the approach can be effectively applied in many other contexts as well. In many cases, procedures have already been developed and used in these community settings for specific instruments, such as the AUDIT. To provide an example, Table 5 summarizes information about the settings, screening personnel, and target groups considered appropriate for a screening program using the a screening instrument.

Table 5: Personnel, Settings and Groups Considered Appropriate for a Screening Program Using Screening Instruments[20]

Setting	Target Group	Screening Personnel
Primary care clinic	Medical patients	Nurse, social worker

[20] Modified from Box 1, Personnel, Settings and Groups Considered Appropriate for a Screening Programme Using the AUDIT (Babor et al., 2001).

Emergency room	Accident victims, Intoxicated patients, trauma victims	Physicians, nurses, or staff, health educators
Physician's office Surgery Prenatal and perinatal clinics	Medical patients	General practitioners, family physicians, physician extenders, nurses, or staff
General Hospital wards Outpatient clinic	Patients with hypertension, heart disease, gastrointestinal or neurological disorders	Internists, physician extenders, nurses, staff
Psychiatric hospital	Psychiatric patients, particularly those who are suicidal	Psychiatrists, psychologists, counselors, staff
Court, jail, prison	DWI offenders, violent criminals	Officers, counselors, probation officers
Other health-related facilities	Persons demonstrating impaired social or occupational functioning (e.g. marital discord, child neglect, etc.)	Health and human service workers
Military Services	Enlisted men and officers	Medics
Welfare Offices	Applicants and clients	Social Workers, case aides
Workplace Employee Assistance Program	Workers, especially those having problems with productivity, absenteeism or accidents	Employee assistance staff

A State could include such efforts in their proposal but must recognize these efforts must comport to the diagnostic considerations outlined here. Examples of such activities can be found in these and other publications:

Inciardi JA Consensus Panel Chair 1994. **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.** Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076

White WL and Dennis M. 20002. The cannabis youth treatment experiment: Key lessons for student assistance programs. *Student Assistance Journal,* 14: 16-19.

Young, N. K. 1996. **Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform**. Washington DC: National Association of State Alcohol and Drug Abuse Directors.

Young N. K., S. L. Gardner, and K. Dennis. 1998. **Responding to Alcohol and other Drug Problems in Child Welfare: Weaving Together practice and Policy**.

Washington DC: Child Welfare League of America Press.

Young NK and Gardner SL. 2002. **Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare**. . Technical Assistance Publication (TAP) Series 27. SAMHSA Publication No. (SMA) 02–3639.

Resources for Developing Need Estimates

Resources that can be referred to for developing estimates of need for treatment and resource availability are:

DeWit DJ and Rush B 1996. Assessing the Need for Substance Abuse Services: A Critical Review of Needs Assessment Models. *Evaluation and Program Planning*. 19(1): 41-64.

Epstein JF 2002. **Substance Dependence, Abuse, and Treatment: Findings from the 2000 National Household Survey on Drug Abuse** (*DHHS Publication No. SMA 02-3642, NHSDA Series A-16*). Rockville MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies

Gerstein D and Harwood H (eds). 1990. **Treating Drug Problems**, Vol. I. Washington DC: National Academy Press. (Chapter 3)

Institute of Medicine. 1990. **Broadening the Base of Treatment for Alcohol Problems**. Washington DC: National Academy Press. (Chapters 7 and 9)

Maxwell JC (ed). 2001. **Multiple Indicator Analysis: Using Secondary Data to Analyze Illicit Drug Use**. DHHS Publication No. (SMA) 01-3539. Rockville, MD: Center for Substance Abuse Treatment and Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

McAuliffeWE, Woodworth R, Zhang CH, and Dunn, RP. 2002. Identifying substance abuse treatment gaps in substate areas. J. *Substance Abuse Treatment*. 23(3): 199-208.

Office of Applied Studies. 2002. **National and State Estimates of the Drug Abuse Treatment Gap: 2000 National Household Survey on Drug Abuse** *(NHSDA Series H-14, DHHS Publication No. SMA 02-3640)*. Rockville, MD: Substance Abuse and Mental Health Services Administration. http://www.samhsa.gov/oas/TXgap/toc.htm

Rush B. 1996. Alcohol and other drug problems and treatment systems: A framework for research and development. *Addiction*. 91(5): 629-642.

Collaboration with Addiction Technology Training Centers as a Training Resource

SAMHSA/CSAT funds a network of 14 independent regional Addiction Technology Transfer Centers (ATTCs) and a National Office (http://www.nattc.org). The ATTCs constitute a nationwide, multi-disciplinary resource that draws upon the knowledge, experience and latest work of recognized experts in the field of addictions. A list of ATTCs, the States covered, and contact information is provided in Table 5. Each ATTC serves as a resource to 2 or more States, having memoranda of understanding with the State Substance Abuse Authorities (SSAs).

Table 5:Addiction Technology Transfer Center Contacts

Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island ATTC of New England Center for Alcohol and Addiction Studies Brown University Providence, Rhode Island 02912 (401) 444-1808 www.attc-ne.org Director: Susan Storti, PhD, RN **New York, New Jersey, Pennsylvania** Northeast ATTC Institute for Research, Education and Training in Addictions Pittsburgh, Pennsylvania 15219 (866) 246-5344 www.ireta.org/attc Director: Michael Flaherty, PhD **District of Columbia, Delaware, Kentucky, Tennessee, Maryland** Central East ATTC DANYA Institute Silver Spring, Maryland 20910 (240) 645-1145 www.ceattc.org **Director: Linda Kaplan, MA**	**Georgia, South Carolina** Southeast ATTC Morehouse School of Medicine CORK Institute Atlanta, Georgia 30310 (404) 756-5742 www.sattc.org Director: Wyeuca Johnson, LCSW, ACSW **Virginia, Maryland, North Carolina, West Virginia** Mid-Atlantic ATTC Virginia Commonwealth University Richmond, Virginia 23298-0469 (804) 828-9910 www.mid-attc.org Director: Paula Horvatich, PhD **Illinois, Ohio, Wisconsin, Indiana, Michigan** Great Lakes ATTC Jane Addams College of Social Work University of Illinois-Chicago Chicago, Illinois 60612 (312) 996-1373 www.glattc.org Director: Lonnetta Albright
Iowa, Nebraska, North Dakota, South Dakota, Minnesota Prairielands ATTC University of Iowa Iowa City, Iowa 52242 (319) 335-5368 www.pattc.org Director: Anne Helene Skinstad, PhD	**California, Arizona, New Mexico** Pacific Southwest ATTC UCLA Integrated Substance Abuse Programs Los Angeles California 90025 (310) 312-0500 http://www.psattc.org/ Director: Thomas Freese, PhD

Nevada, Montana, Wyoming, Utah, Colorado Mountain West ATTC University of Nevada, Reno Reno, Nevada 89557 (775) 784-6265 www.mwattc.org Principal Investigator: Nancy Roget, MS Co-PI: Gary L. Fisher, PhD **Alaska, Washington, Oregon, Idaho, Hawaii, Pacific Islands** Northwest Frontier ATTC Salem, Oregon 97303 (503) 373-1322 www.nfattc.org Director: Steve Gallon, PhD **Texas, Louisiana, Mississippi** Gulf Coast ATTC University of Texas Center for Social Work Research Austin, Texas 78703 (512) 232-0616 www.utattc.net Director: Richard Spence, PhD	Co-Director: Michael Shafer, PhD **Puerto Rico, US Virgin Islands** Caribbean Basin and Hispanic ATTC Centro de Estudios en Adiccion Universidad Central del Caribe Call Box 60-327 Bayamon, Puerto Rico 00960-6032 (787) 785-4211 web http://cbattc.uccaribe.edu/ Director: Rafaela Robles, EdD **Alabama, Florida** Southern Coast ATTC Florida Certification Board Tallahassee Florida 32301 (850) 222-6731 www.scattc.org Director: Pam Waters **National Office** University of Missouri - Kansas City Kansas City, MO 64110-2499 (816) 482-1200 http://www.nattc.org/ Director: Mary Beth Johnson, MSW

APPENDIX B
CSAT's GPRA STRATEGY

OVERVIEW

The Government Performance and Results Act of 1993 (Public Law-103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a three to five year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met. In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to "explain" their success and failures based on the performance monitoring data. While the language of the statute talks about separate Annual Performance Plans and Annual Performance Reports, ASMB/HHS has chosen to incorporate the elements of the annual reports into the annual President's Budget and supporting documents. The following provides an overview of how the Center for Substance Abuse Treatment, in conjunction with the Office of the Administrator/SAMHSA, CMHS, and CSAP, are addressing these statutory requirements.

DEFINITIONS

Performance Monitoring	The ongoing measurement and reporting of program accomplishments, particularly progress towards preestablished goals. The monitoring can involve process, output, and outcome measures.
Evaluation	Individual systematic studies conducted periodically or "as needed" to assess how well a program is working and why particular outcomes have (or have not) been achieved.
Program	For GPRA reporting purposes, a set of activities that have a common purpose and for which targets can (will) be established.[21]
Activity	A group of grants, cooperative agreements, and contracts that together are directed toward a common objective.
Project	An individual grant, cooperative agreement, or contract.

[21]GPRA gives agencies broad discretion with respect to how its statutory programs are aggregated or disaggregated for GPRA reporting purposes.

CENTER (OR MISSION) GPRA OUTCOMES

The mission of the Center for Substance Abuse Treatment is to support and improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. However, it is not the only agency in the Federal government that has substance abuse treatment as part of its mission. The Health Care Financing Administration, Department of Veterans Affairs, and the Department of Justice all provide considerable support to substance abuse treatment. It shares with these agencies responsibility for achieving the objectives and targets for Goal 3 of the Office of National Drug Control Policy's Performance Measures of Effectiveness:

Reduce the Health and Social Costs Associated with Drug Use.

Objective 1 is to support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse. The individual target areas under this objective include reducing the treatment gap (Goal 3.1.1), demonstrating improved effectiveness for those completing treatment (Goal 3.1.2), reducing waiting time for treatment (Goal 3.1.3), implementing a national treatment outcome monitoring system (Goal 3.1.4), and disseminating treatment information (Goal 3.1.5). Objective 4 is to support and promote the education, training, and credentialing of professionals who work with substance abusers.

CSAT works closely with ONDCP, and other Federal demand reduction agencies to develop annual targets and to implement a data collection/information management strategy that will provide the necessary measures to report on an annual basis on progress toward the targets presented in the ONDCP plan. These performance measures will, at an aggregate level, provide a measure of the overall success of CSAT's activities. While it will be extremely difficult to attribute success or failure in meeting ONDCP's goals to individual programs or agencies, CSAT is committed to working with ONDCP on evaluations designed to attempt to disaggregate the effects. With regard to the data necessary to measure progress, the National Household Survey on Drug Abuse (conducted by SAMHSA) is the principal source of data on prevalence of drug abuse and on the treatment gap. Assessing progress on improving effectiveness for those completing treatment requires the implementation of a national treatment outcome monitoring system (Target 3.1.4). ONDCP is funding an effort to develop such a system and it is projected in Performance Measures of Effectiveness to be completed by FY 2002.

Until the system is able to provide data CSAT will rely on more limited data, generated within its own funded grant programs, to provide an indication of the impact that our efforts are having in these particular target areas. It will not be representative of the overall national treatment system, nor of all Federal activities that could affect these outcomes. For example, from its targeted capacity expansion program CSAT can present baseline data on the numbers of individuals treated, percent completing treatment, percent not using illegal drugs, percent employed, and percent engaged in illegal activity (i.e., measures indicated in the ONDCP targets) in its FY 2002 report with targets for future years. As the efforts to incorporate outcome indicators into the SAPT Block Grant are completed over the next several years, these will be added to the outcomes reported from the targeted capacity expansion program.

In addition to these "end" outcomes, it is suggested that CSAT consider a routine customer service survey to provide the broadest possible range of customers (and potential customers) with a means of providing feedback on our services and input into future efforts. We would propose an annual survey with a short, structured questionnaire that would also include an unstructured opportunity for respondents to provide additional input if they so choose.

CSAT's "PROGRAMS" FOR GPRA REPORTING PURPOSES

All activities in SAMHSA (and, therefore, CSAT) have been divided into three broad areas or "programmatic goals" for GPRA reporting purposes:

- Goal 1: Assure services availability;
- Goal 2: Meet unmet and emerging needs;
- Goal 3: Identify and implement best practices

For each GPRA [program] goal, a standard set of output measures has been identified for CSAT activities to provide the basis for establishing targets and reporting performance.

1. ASSURE SERVICES AVAILABILITY

Into this program goal area fall the major services activities of CSAT: the Substance Abuse Prevention and Treatment Block Grant. In FY 2000 the Block grant application was revised and approved by the Office of Management and Budget to permit the voluntary collection of data from the States. More specifically:

- Number of clients served (unduplicated)
- Increase % of adults receiving services who:
  - (a) were currently employed or engaged in productive activities;
  - (b) had a permanent place to live in the community;
  - (c) had no/reduced involvement with the criminal justice system.
- Percent decrease in
  - (a) Alcohol use;
  - (b) Marijuana use;
  - (c) Cocaine use;
  - (d) Amphetamine use
  - (e) Opiate use

In addition, in the Fall of 1999 a customer satisfaction survey was designed and approved for collection from each state on the level of satisfaction with Technical Assistance and Needs Assessment Services provided to the States. More specifically:

- Increase % of States that express satisfaction with TA provided
- Increase % of TA events that result in systems, program or practice improvements

2. MEET UNMET OR EMERGING NEEDS

Into this program goal area fall the major services activities of CSAT: Targeted Capacity Expansion Grants. Simplistically, the following questions need to be answered about these activities within a performance monitoring context:

- Were identified needs met?
- Was service availability improved?
- Are client outcomes good (e.g., better than benchmarks)?

The client outcome assessment strategy mentioned earlier will provide the data necessary for CSAT to address these questions. The strategy, developed and shared by the three Centers, involves requiring each SAMHSA project that involves services to individuals to collect a uniform set of data elements from each individual at admission to services and 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- Percent of adults receiving services who:
  a) were currently employed or engaged in productive activities
  b) had a permanent place to live in the community
  c) had reduced involvement with the criminal justice system
  d) had no past month use of illegal drugs or misuse of prescription drugs
  e) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs

- Percent of children/adolescents under age 18 receiving services who:
  a) were attending school
  b) were residing in a stable living environment
  c) had no involvement in the juvenile justice system
  d) had no past month use of alcohol or illegal drugs
  e) experienced reduced substance abuse related health, behavior, or social. consequences.

These data, combined with data taken from the initial grant applications, will enable CSAT to address each of the critical success questions.

3. IDENTIFY AND IMPLEMENT BEST PRACTICES

This "program" involves promoting the adoption of best practices and is synonymous currently with Knowledge Application.[22] Within CSAT, these activities currently include the

[22]Most, if not all, of the activities conducted under the rubric of technical assistance and infrastructure development are appropriately classified as activities supporting this program goal.

Product Development and Targeted Dissemination contract (to include TIPS, TAPS, and Substance Abuse in Brief), the Addiction Technology Transfer Centers, the Practice Improvement Collaboratives, and the Conference Grants.

Activities in this program have the purpose of moving "best practices", as determined by research and other knowledge development activities, into routine use in the treatment system. Again simplistically, the immediate success of these activities can be measured by the extent to which they result in the adoption of a "best practice."[23] In order to provide appropriate GPRA measures in this area, CSAT plans to require that all activities that contribute to this goal to collect information on the numbers and types of services rendered, the receipt of the service by the clients and their satisfaction with the services, and whether the services resulted in the adoption of a best practice related to the service rendered.

EVALUATIONS

As defined earlier, evaluation refers to periodic efforts to validate performance monitoring data; to examine, in greater depth, the reasons why particular performance measures are changing (positively or negatively); and to address specific questions posed by program managers about their programs. These types of evaluation are explicitly described, and expected, within the GPRA framework. In fact, on an annual basis, the results of evaluations are to be presented and future evaluations described.

To date, CSAT has not developed any evaluations explicitly within the GPRA framework. The initial requirements will, of necessity, involve examinations of the reliability and validity of the performance measures developed in each of the four program

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Technical assistance activities within GPRA have not been discussed within CSAT. Further, at this time, SAMHSA has a separate program goal for infrastructure development (see "Enhance Service System Performance," below).

[23]Ultimately, the increased use of efficient and effective practices should increase the availability of services and effectiveness of the system in general. However, measures of treatment availability and effectiveness are not currently available. Within existing resources, it would not be feasible to consider developing a system of performance measurement for this purpose.

areas. At the same time, it is expected that CSAT managers will begin to ask questions about the meaning of the performance monitoring data as they begin to come in and be analyzed and reported. This will provide the opportunity to design and conduct evaluations that are tied to "real" management questions and, therefore, of greater potential usefulness to CSAT. CSAT will be developing a GPRA support contract that permits CSAT to respond flexibly to these situations as they arise.

On a rotating basis, program evaluations will be conducted to validate the performance monitoring data and to extend our understanding of the impacts of the activities on the adoption of best practices.

Form Approved
OMB No. 0930-0208
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APPENDIX C

CSAT GPRA Client Outcome Measures for Discretionary Programs

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|____|____|

Interview Type

1. Intake
2. 6 month follow-up
3. 12 month follow-up
4. 3 month follow-up

Service Type

For *intake* interview: What service type *will* the client receive in your program? (Check all that apply.)

_____ 1. Case Management
_____ 2. Day Treatment
_____ 3. Inpatient
_____ 4. Outpatient
_____ 5. Outreach
_____ 6. Intensive Outpatient
_____ 7. Methadone
_____ 8. Residential
_____ 9. Other _____
_____ 10. Other _____
_____ 11. Other_____

B. DRUG AND ALCOHOL USE

1. During the past 30 days how many days have you used the following: **Number of Days**

a. Any alcohol |____|____|
b1. Alcohol to intoxication (5+ drinks in one sitting) |____|____|
b2. Alcohol to intoxication (4 or fewer drinks and felt high) |____|____|
c. Illegal drugs |____|____|

2. During the past 30 days, how many days have you used any of the following: **Number of Days**

a. Cocaine/Crack |____|____|
|____|____|

b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)

c. Heroin (Smack, H, Junk, Skag), or other opiates:
1. Heroin (Smack, H, Junk, Skag) |____|____|
2. Morphine |____|____|
3. Diluadid |____|____|
4. Demerol |____|____|
5. Percocet |____|____|
6. Darvon |____|____|
7. Codeine |____|____|
8. Tylenol 2,3,4 |____|____|

d. Non-prescription methadone |____|____|

e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline
|____|____|

f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)
|____|____|

g. 1. Benzodiazepines: Diazepam (Valium); Alpeazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol– also known as roofies, roche, and cope) |____|____|
2. Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal) |____|____|
3. Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy) |____|____|
4. Ketamine (known as Special K or Vitamin K) |____|____|
5. Other tranquilizers, downers, sedatives or hypnotics |____|____|

h. Inhalants (poppers, snappers, rush, whippets) |____|____|

i. Other illegal drugs (specify) _____ |____|____|

3. In the past 30 days have you injected drugs? ○ Yes ○ No
If no, go to Section C.

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

- ○ Always
- ○ More then half the time
- ○ Half the time
- ○ Less then half the time
- ○ Never

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time?

- ○ Shelter (safe havens, TLC, low demand facilities, reception centers, other temporary day or evening facility)
- ○ Street/outdoors (sidewalk, doorway, park, public or abandoned building)
- ○ Institution (hospital, nursing home, jail/prison)
- ○ Housed:
  - ○ Own/rent apartment, room, or house
  - ○ Someone else's apartment, room or house
  - ○ Halfway house
  - ○ Residential treatment
  - ○ Other housed (specify)_____

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ Not applicable

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ Not applicable

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ Not Applicable

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? (IF ENROLLED: Is that full time or part time?)

- ○ Not enrolled
- ○ Enrolled, full time
- ○ Enrolled, part time
- ○ Other (specify)_____

2. What is the highest level of education you have finished, whether or not you received a degree? (01=1st grade, 12=12th grade, 13=college freshman, 16=college completion)

|____|____| level in years

2a. If less than 12 years of education, do you have a GED (General Equivalency Diploma)?

○ Yes ○ No

3. Are you currently employed? (Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work)

- ○ Employed full time (35+ hours per week, or would have been)
- ○ Employed part time
- ○ Unemployed, looking for work
- ○ Unemployed, disabled
- ○ Unemployed, volunteer work
- ○ Unemployed, retired
- ○ Unemployed, not looking for work
- ○ Other (specify) _____

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from…

	INCOME
a. Wages	$, .00
b. Public assistance	$, .00
c. Retirement	$, .00
d. Disability	$, .00
e. Non-legal income	$, .00
f. Other (specify) _____	$, .00

E. CRIME AND CRIMINAL JUSTICE STATUS

1. **In the past 30 days, how many times have you been arrested?** |____|____| times
If no arrests, go to item E3

2. **In the past 30 days, how many times have you been arrested for drug-related offenses?** |____|____| times

3. **In the past 30 days, how many nights have you spent in jail/prison?** |____|____| nights

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. **How would you rate your overall health right now?**

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:	No	Yes ⇨	**If yes, altogether** for how many nights (DK=98)
i. Physical complaint	○	○	_____
ii. Mental or emotional difficulties	○	○	_____
iii. Alcohol or substance abuse	○	○	_____

b. Outpatient Treatment for:	No	Yes ⇨	**If yes, altogether** how many times (DK=98)
i. Physical complaint	○	○	_____
ii. Mental or emotional difficulties	○	○	_____
iii. Alcohol or substance abuse	○	○	_____

c. Emergency Room Treatment for:	No	Yes ⇨	**If yes, altogether** for how many times (DK=98)
i. Physical complaint	○	○	_____
ii. Mental or emotional difficulties	○	○	_____
iii. Alcohol or substance abuse	○	○	_____

3. During the past 30 days, did you engage in sexual activity?

○ Not permitted to ask ○ Yes ○ No

	If yes, altogether How many (DK=98)
a. Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|____|
b. Unprotected sexual contacts did you have?	|____|____|____|
c. Unprotected sexual contacts were with an individual who is or was:	
1. HIV positive or has AIDS	|____|____|____|
2. An injection drug user	|____|____|____|
3. High on some substance	|____|____|____|

4. In the past 30 days (not due to your use of alcohol or drugs) how many days have you:

a. Experienced serious depression	|____|____|
b. Experienced serous anxiety or tension	|____|____|
c. Experienced hallucinations	|____|____|
d. Experienced trouble understanding, concentrating, or remembering	|____|____|
e. Experienced trouble controlling violent behavior	|____|____|
f. Attempted suicide	|____|____|
g. Been prescribed medication for psychological/emotional problem	|____|____|

4a. If you reported one or more days in question 4, how much have you been bothered by these psychological or emotional problems in the past 30 days? (If you did not report any days to the items in question 4, skip to the next question.)

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerable
- ○ Extremely

H. DEMOGRAPHICS (ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female
- ○ Transgender
- ○ Other (specify) _____

2. Are you Hispanic or Latino?

○ Yes ○ No

If yes, what ethnic group do you consider yourself? **(CSAT ONLY)**

- ○ Central American
- ○ Cuban
- ○ Dominican
- ○ Mexican
- ○ Puerto Rican
- ○ South American
- ○ Other, specify _____

3. What is your race? (Select one or more)

- ○ Black or African American
- ○ Asian
- ○ American Indian
- ○ Native Hawaiian or other Pacific Islander
- ○ Alaska Native
- ○ White
- ○ Other (specify)_____

4. What is your date of birth? |____|____| / |____|____| / |____|____|____|____|
Month / Day / Year

I. FOLLOW-UP STATUS (REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP)

1. What is the follow-up status of the client?

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed within specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other

J. DISCHARGE STATUS (REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP)

1. On what date was the client discharged? |____|____| / |____|____| / |____|____|____|____|
Month / Day / Year

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? (Select one response.)

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other _____

3. During the course of treatment in your project, what types of services did the client receive? (Check all that apply and tell how many weeks the client spent in each service.)

_____ 1. Case Management _____ weeks
_____ 2. Day Treatment _____ weeks
_____ 3. Inpatient _____ weeks
_____ 4. Outpatient _____ weeks
_____ 5. Outreach _____ weeks
_____ 6. Intensive Outpatient _____ weeks
_____ 7. Methadone _____ weeks
_____ 8. Residential _____ weeks
_____ 9. Other _____ _____ weeks
_____ 10. Other _____ _____ weeks
_____ 11. Other_____ _____ weeks

Appendix D
References and Resources

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